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State of Minnesota

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Page No. **384**

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. **4338**

- 03/16/2026 Authored by Schomacker and Noor
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy
- 04/22/2026 Adoption of Report: Amended and re-referred to the Committee on Ways and Means
- 05/06/2026 Adoption of Report: Placed on the General Register as Amended
Read for the Second Time
- 05/07/2026 Referred to the Chief Clerk for Comparison with S. F. No. 4476
- 05/11/2026 Postponed Indefinitely

1.1 A bill for an act

1.2 relating to state government; modifying provisions relating to human services

1.3 health care, the Department of Human Services Office of Inspector General,

1.4 background studies, behavioral health services, uniform service standards, aging

1.5 and disability services, and assisted living facilities; establishing working groups;

1.6 making technical corrections; requiring reports; appropriating money; amending

1.7 Minnesota Statutes 2024, sections 13.46, subdivision 7; 13A.03, by adding a

1.8 subdivision; 142B.01, subdivision 8; 144.292, subdivision 6; 144.294, subdivision

1.9 2; 144G.41, subdivision 1, by adding a subdivision; 245.095, subdivisions 2, 5,

1.10 by adding a subdivision; 245.4661, subdivision 10, by adding subdivisions;

1.11 245.4711, subdivision 5; 245.4881, subdivision 5; 245.4882, subdivision 6; 245.735,

1.12 subdivision 6; 245A.02, subdivision 5a; 245A.07, subdivision 2a; 245A.10, by

1.13 adding a subdivision; 245A.26, subdivisions 3, 4, 5; 245A.65, subdivision 1a;

1.14 245C.02, subdivision 18; 245C.03, subdivisions 1, 3a, 9, by adding subdivisions;

1.15 245C.04, subdivision 1; 245C.10, subdivision 8; 245C.15, subdivisions 2, 3, 4;

1.16 245C.24, subdivision 2; 245D.04, subdivision 3; 245D.081, subdivision 3; 245D.10,

1.17 subdivision 4; 245D.12; 245G.03, subdivision 1; 245I.011, subdivisions 3, 5, by

1.18 adding a subdivision; 245I.02, subdivisions 33, 39, by adding subdivisions; 245I.03,

1.19 subdivision 4, by adding a subdivision; 245I.06, subdivisions 1, 2; 245I.07; 245I.10,

1.20 subdivisions 6, 8, by adding a subdivision; 245I.23, subdivisions 4, 5, 8, 12, 16,

1.21 17; 254A.03, subdivision 2; 254B.17; 256.975, subdivision 7b; 256B.02, by adding

1.22 a subdivision; 256B.04, subdivisions 5, 10, 23, by adding a subdivision; 256B.0623,

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

1.24 adding a subdivision; 256B.0625, subdivision 17b, by adding a subdivision;

1.25 256B.064, subdivisions 1b, 1c, 1d, 2, 3, 4, 5, by adding subdivisions; 256B.0651,

1.26 subdivision 17; 256B.0671, by adding a subdivision; 256B.073, subdivisions 1,

1.27 2, 3, 5, by adding subdivisions; 256B.076, subdivision 1, by adding subdivisions;

1.28 256B.0761, subdivisions 2, 3; 256B.0911, subdivision 32; 256B.092, subdivision

1.29 14; 256B.094, subdivisions 2, 3, 6, 7; 256B.0943, subdivision 2, by adding a

1.30 subdivision; 256B.0949, subdivision 17, by adding a subdivision; 256B.198;

1.31 256B.27, subdivision 3; 256B.49, subdivision 25; 256B.4905, subdivisions 11,

1.32 12; 256B.4912, by adding a subdivision; 256B.4914, subdivision 6d, by adding a

1.33 subdivision; 256B.492, by adding a subdivision; 256B.69, subdivision 5a, by

1.34 adding a subdivision; 256B.85, subdivision 23a; 256S.20, by adding a subdivision;

1.35 256S.21, by adding a subdivision; 295.50, subdivision 4; 297E.02, subdivision 3;

1.36 Minnesota Statutes 2025 Supplement, sections 15.013, by adding a subdivision;

1.37 15.471, subdivision 6; 144.0724, subdivision 11; 245.4661, subdivision 9; 245.4835,

1.38 subdivision 2; 245.4871, subdivision 4; 245.735, subdivision 4d; 245A.03,

2.1 subdivision 2; 245A.04, subdivisions 1, 7; 245A.05; 245A.07, subdivision 3;
 2.2 245A.10, subdivisions 3, 4; 245A.142, subdivision 3; 245A.242, subdivision 2;
 2.3 245C.02, subdivision 15a; 245C.05, subdivision 5; 245C.07; 245C.13, subdivision
 2.4 2; 245C.15, subdivision 4a; 245C.16, subdivision 1; 245C.22, subdivision 5;
 2.5 245I.04, subdivisions 5, 17; 245I.23, subdivisions 7, 10; 254B.02, subdivision 5;
 2.6 254B.0503, subdivision 1; 254B.0505, subdivision 8, by adding a subdivision;
 2.7 254B.0509, subdivision 2; 256B.04, subdivision 21; 256B.051, subdivision 6;
 2.8 256B.0625, subdivisions 5m, 17, 20; 256B.0659, subdivision 21; 256B.0701,
 2.9 subdivision 9; 256B.0759, subdivision 4; 256B.0911, subdivision 14; 256B.0924,
 2.10 subdivision 6; 256B.0943, subdivisions 3, 12; 256B.0949, subdivision 16;
 2.11 256B.4914, subdivision 8; 256B.85, subdivisions 12, 17a; 256I.04, subdivision
 2.12 2a; 256L.03, subdivision 5; 260E.03, subdivision 6; 260E.11, subdivision 1;
 2.13 260E.14, subdivision 1; 295.50, subdivision 9b; 626.5572, subdivision 13; Laws
 2.14 2024, chapter 125, article 8, section 2, subdivisions 4, 14, as amended; Laws 2025,
 2.15 First Special Session chapter 9, article 4, sections 2; 23; 38; 39; 40; 41; 42; 43;
 2.16 44; 50; proposing coding for new law in Minnesota Statutes, chapters 245A; 245I;
 2.17 256B; repealing Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a,
 2.18 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, 8; 245C.03, subdivision 7; 245I.20,
 2.19 subdivision 9; 245I.23, subdivision 23; 256B.055, subdivision 14; 256B.0623,
 2.20 subdivisions 2, 4, 5, 6, 9; 256B.0624, subdivisions 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9,
 2.21 11; 256B.073, subdivision 4; 256B.0911, subdivision 21; 256B.0943, subdivisions
 2.22 4, 5, 5a, 6, 7, 11; Minnesota Statutes 2025 Supplement, sections 245.735,
 2.23 subdivisions 3, 4d; 245A.10, subdivision 3a; 256B.0701, subdivision 11;
 2.24 256B.0943, subdivisions 1, 9; Minnesota Rules, part 9505.2165, subpart 4.

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

2.26

ARTICLE 1

2.27

HEALTH CARE

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

2.30 Subd. 7. **Exemption.** Nothing in this section modifies, supersedes, limits, or expands
 2.31 the authority of the commissioner of human services to impose sanctions under section
 2.32 256B.064.

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

2.34 Sec. 2. Minnesota Statutes 2024, section 142B.01, subdivision 8, is amended to read:

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

2.38 (1) each officer of the organization, including the chief executive officer and chief
 2.39 financial officer;

2.40 (2) the individual designated as the authorized agent under section 142B.10, subdivision
 2.41 1, paragraph (b);

3.1 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
3.2 ~~21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

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

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

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

3.8 (b) Controlling individual does not include:

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

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

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

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

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

3.21 (4) an individual who is a member of an organization exempt from taxation under section
3.22 290.05, unless the individual is also an officer, owner, or managerial official of the program
3.23 or owns any of the beneficial interests not excluded in this subdivision. This clause does
3.24 not exclude from the definition of controlling individual an organization that is exempt from
3.25 taxation; or

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

3.29 (c) For purposes of this subdivision, "managerial official" means an individual who has
3.30 the decision-making authority related to the operation of the program, and the responsibility
3.31 for the ongoing management of or direction of the policies, services, or employees of the

4.1 program. A site director who has no ownership interest in the program is not considered to
4.2 be a managerial official for purposes of this definition.

4.3 Sec. 3. Minnesota Statutes 2024, section 144.292, subdivision 6, is amended to read:

4.4 Subd. 6. **Cost.** (a) When a patient requests a copy of the patient's record for purposes of
4.5 reviewing current medical care, the provider must not charge a fee.

4.6 (b) When a provider or its representative makes copies of patient records upon a patient's
4.7 request under this section, the provider or its representative may charge the patient or the
4.8 patient's representative no more than the following amount, unless other law or a rule or
4.9 contract provide for a lower maximum charge:

4.10 (1) for paper copies, \$1 per page, plus \$10 for time spent retrieving and copying the
4.11 records;

4.12 (2) for x-rays, a total of \$30 for retrieving and reproducing x-rays; and

4.13 (3) for electronic copies, a total of \$20 for retrieving the records.

4.14 (c) For any copies of paper records provided under paragraph (b), clause (1), a provider
4.15 or the provider's representative may not charge more than a total of:

4.16 (1) \$10 if there are no records available;

4.17 (2) \$30 for copies of records of up to 25 pages;

4.18 (3) \$50 for copies of records of up to 100 pages;

4.19 (4) \$50, plus an additional 20 cents per page for pages 101 and above; or

4.20 (5) \$500 for any request.

4.21 (d) A provider or its representative may charge a \$10 retrieval fee, but must not charge
4.22 a per page fee or x-ray fee to provide copies of records requested by a patient or the patient's
4.23 authorized representative if the request for copies of records is for purposes of appealing a
4.24 denial of Social Security disability income or Social Security disability benefits under title
4.25 II or title XVI of the Social Security Act or for purposes of a disability determination by
4.26 the department's state medical review team. Notwithstanding the foregoing, a provider or
4.27 its representative must not charge a fee, including a retrieval fee, to provide copies of records
4.28 requested by a patient or the patient's authorized representative if the request for copies of
4.29 records is for purposes of appealing a denial of Social Security disability income or Social
4.30 Security disability benefits under title II or title XVI of the Social Security Act or for purposes
4.31 of a disability determination by the department's state medical review team when the patient

5.1 is receiving public assistance, represented by an attorney on behalf of a civil legal services
5.2 program, or represented by a volunteer attorney program based on indigency. The patient
5.3 or the patient's representative must submit one of the following to show that they are entitled
5.4 to receive records without charge under this paragraph:

5.5 (1) a public assistance statement from the county or state administering assistance;

5.6 (2) a request for records on the letterhead of the civil legal services program or volunteer
5.7 attorney program based on indigency; or

5.8 (3) a benefits statement from the Social Security Administration.

5.9 For the purpose of further appeals, a patient may receive no more than two medical record
5.10 updates without charge, but only for medical record information previously not provided.

5.11 For purposes of this paragraph, a patient's authorized representative does not include units
5.12 of state government engaged in the adjudication of Social Security disability claims.

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

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

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

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

5.19 Sec. 5. Minnesota Statutes 2024, section 245.4711, subdivision 5, is amended to read:

5.20 **Subd. 5. Coordination between case manager and community support services.** (a)
5.21 The county board must establish procedures that ensure ongoing contact and coordination
5.22 between the case manager and the community support services program as well as other
5.23 mental health services.

5.24 (b) At a minimum, the case manager must have at least one case management contact
5.25 with a documented core service component, as defined by the commissioner, to claim
5.26 reimbursement for adult mental health targeted case management. Adult mental health case
5.27 managers must not conduct the required case management contact by telephone with the
5.28 adult client or the adult client's legal representative for more than two consecutive calendar
5.29 months.

6.1 Sec. 6. Minnesota Statutes 2024, section 245.4881, subdivision 5, is amended to read:

6.2 Subd. 5. **Coordination between case manager and family community support**
6.3 **services.** (a) The county board must establish procedures that ensure ongoing contact and
6.4 coordination between the case manager and the family community support services as well
6.5 as other mental health services for each child.

6.6 (b) At a minimum, the case manager must have at least one contact in every calendar
6.7 month, conducted in person or by interactive video that meets the requirements of section
6.8 256B.0625, subdivision 20b, with the child, the child's parents, or the child's legal
6.9 representative.

6.10 Sec. 7. Minnesota Statutes 2024, section 245A.02, subdivision 5a, is amended to read:

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

6.14 (1) each officer of the organization, including the chief executive officer and chief
6.15 financial officer;

6.16 (2) the individual designated as the authorized agent under section 245A.04, subdivision
6.17 1, paragraph (b);

6.18 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
6.19 ~~21, paragraph (g)~~ 256B.044, subdivision 8, paragraph (b);

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

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

6.23 (b) Controlling individual does not include:

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

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

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

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

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

7.5 (4) an individual who is a member of an organization exempt from taxation under section
7.6 290.05, unless the individual is also an officer, owner, or managerial official of the program
7.7 or owns any of the beneficial interests not excluded in this subdivision. This clause does
7.8 not exclude from the definition of controlling individual an organization that is exempt from
7.9 taxation; or

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

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

7.18 Sec. 8. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 1, is amended
7.19 to read:

7.20 Subdivision 1. **Application for licensure.** (a) An individual, organization, or government
7.21 entity that is subject to licensure under section 245A.03 must apply for a license. The
7.22 application must be made on the forms and in the manner prescribed by the commissioner.
7.23 The commissioner shall provide the applicant with instruction in completing the application
7.24 and provide information about the rules and requirements of other state agencies that affect
7.25 the applicant. An applicant seeking licensure in Minnesota with headquarters outside of
7.26 Minnesota must have a program office located within 30 miles of the Minnesota border.
7.27 An applicant who intends to buy or otherwise acquire a program or services licensed under
7.28 this chapter that is owned by another license holder must apply for a license under this
7.29 chapter and comply with the application procedures in this section and section 245A.043.

7.30 The commissioner shall act on the application within 90 working days after a complete
7.31 application and any required reports have been received from other state agencies or
7.32 departments, counties, municipalities, or other political subdivisions. The commissioner
7.33 shall not consider an application to be complete until the commissioner receives all of the

8.1 required information. If the applicant or a controlling individual is the subject of a pending
8.2 administrative, civil, or criminal investigation, the application is not complete until the
8.3 investigation has closed or the related legal proceedings are complete.

8.4 When the commissioner receives an application for initial licensure that is incomplete
8.5 because the applicant failed to submit required documents or that is substantially deficient
8.6 because the documents submitted do not meet licensing requirements, the commissioner
8.7 shall provide the applicant written notice that the application is incomplete or substantially
8.8 deficient. In the written notice to the applicant the commissioner shall identify documents
8.9 that are missing or deficient and give the applicant 45 days to resubmit a second application
8.10 that is substantially complete. An applicant's failure to submit a substantially complete
8.11 application after receiving notice from the commissioner is a basis for license denial under
8.12 section 245A.043.

8.13 (b) An application for licensure must identify all controlling individuals as defined in
8.14 section 245A.02, subdivision 5a, and must designate one individual to be the authorized
8.15 agent. The application must be signed by the authorized agent and must include the authorized
8.16 agent's first, middle, and last name; mailing address; and email address. By submitting an
8.17 application for licensure, the authorized agent consents to electronic communication with
8.18 the commissioner throughout the application process. The authorized agent must be
8.19 authorized to accept service on behalf of all of the controlling individuals. A government
8.20 entity that holds multiple licenses under this chapter may designate one authorized agent
8.21 for all licenses issued under this chapter or may designate a different authorized agent for
8.22 each license. Service on the authorized agent is service on all of the controlling individuals.
8.23 It is not a defense to any action arising under this chapter that service was not made on each
8.24 controlling individual. The designation of a controlling individual as the authorized agent
8.25 under this paragraph does not affect the legal responsibility of any other controlling individual
8.26 under this chapter.

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

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

9.4 (e) The commissioner may limit communication during the application process to the
9.5 authorized agent or the controlling individuals identified on the license application and for
9.6 whom a background study was initiated under chapter 245C. Upon implementation of the
9.7 provider licensing and reporting hub, applicants and license holders must use the hub in the
9.8 manner prescribed by the commissioner. The commissioner may require the applicant,
9.9 except for child foster care, to demonstrate competence in the applicable licensing
9.10 requirements by successfully completing a written examination. The commissioner may
9.11 develop a prescribed written examination format.

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

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

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

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

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

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

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

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

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

9.30 (3) the first, middle, and last name, and address for all individuals who will be controlling
9.31 individuals, including all officers, owners, and managerial officials as defined in section

10.1 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant
10.2 for each controlling individual;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

11.12 (1) the licensure application;

11.13 (2) the renewal application;

11.14 (3) any documentation or written policies submitted with the licensure application;

11.15 (4) any documentation or written policies submitted with the renewal application; or

11.16 (5) any documentation or written policies maintained as a requirement of licensure or
11.17 enrollment as a medical assistance provider.

11.18 Sec. 9. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 7, is amended
11.19 to read:

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

11.24 (1) the name of the license holder;

11.25 (2) the address of the program;

11.26 (3) the effective date and expiration date of the license;

11.27 (4) the type of license and the specific service the license holder is licensed to provide;

11.28 (5) the maximum number and ages of persons that may receive services from the program;

11.29 and

11.30 (6) any special conditions of licensure.

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

12.2 (1) the commissioner is unable to conduct the observation required by subdivision 4,
12.3 paragraph (a), clause (3), because the program is not yet operational;

12.4 (2) certain records and documents are not available because persons are not yet receiving
12.5 services from the program; and

12.6 (3) the applicant complies with applicable laws and rules in all other respects.

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

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

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

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

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

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

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

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

12.29 (f) Notwithstanding paragraph (d), the commissioner may issue a new license in response
12.30 to an application that is affiliated with an applicant, license holder, or controlling individual
12.31 that had an application denied within the past two years or a license revoked within the past
12.32 five years if the commissioner determines that (1) the applicant or controlling individual

13.1 has operated one or more programs in substantial compliance with applicable laws and rules
13.2 and (2) the program's operation would be in the best interests of the community to be served.

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

13.8 (h) The commissioner shall not issue or reissue a license under this chapter if an individual
13.9 living in the household where the services will be provided as specified under section
13.10 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside
13.11 and no variance has been granted.

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

13.18 (j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of
13.19 a controlling individual or license holder, and the controlling individual or license holder
13.20 is ordered under section 245C.17 to be immediately removed from direct contact with
13.21 persons receiving services or is ordered to be under continuous, direct supervision when
13.22 providing direct contact services, the program may continue to operate only if the program
13.23 complies with the order and submits documentation demonstrating compliance with the
13.24 order. If the disqualified individual fails to submit a timely request for reconsideration, or
13.25 if the disqualification is not set aside and no variance is granted, the order to immediately
13.26 remove the individual from direct contact or to be under continuous, direct supervision
13.27 remains in effect pending the outcome of a hearing and final order from the commissioner.

13.28 (k) Unless otherwise specified by statute, all licenses issued under this chapter expire
13.29 at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must
13.30 comply with the requirements in section 245A.10 and be reissued a new license to operate
13.31 the program or the program must not be operated after the expiration date. Adult foster care,
13.32 family adult day services, child foster residence setting, and community residential services
13.33 license holders must apply for and be granted a new license to operate the program or the

14.1 program must not be operated after the expiration date. Upon implementation of the provider
14.2 licensing and reporting hub, licenses may be issued each calendar year.

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

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

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

14.11 Sec. 10. Minnesota Statutes 2025 Supplement, section 245A.05, is amended to read:

14.12 **245A.05 DENIAL OF APPLICATION.**

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

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

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

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

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

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

14.25 (6) is associated with an individual who received a background study under section
14.26 245C.03, subdivision 1, paragraph (a), clause (6), who may have unsupervised access to
14.27 children or vulnerable adults, and who has a disqualification that has not been set aside
14.28 under section 245C.22, and no variance has been granted;

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

14.30 (8) fails to demonstrate competent knowledge as required by section 245A.04, subdivision
14.31 6;

15.1 (9) has a history of noncompliance as a license holder or controlling individual with
15.2 applicable laws or rules, including but not limited to this chapter and chapters 142E and
15.3 245C;

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

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

15.6 (b) An applicant whose application has been denied by the commissioner must be given
15.7 notice of the denial, which must state the reasons for the denial in plain language. Notice
15.8 must be given by certified mail, by personal service, or through the provider licensing and
15.9 reporting hub. The notice must state the reasons the application was denied and must inform
15.10 the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules,
15.11 parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the
15.12 commissioner in writing by certified mail, by personal service, or through the provider
15.13 licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the
15.14 commissioner within 20 calendar days after the applicant received the notice of denial. If
15.15 an appeal request is made by personal service, it must be received by the commissioner
15.16 within 20 calendar days after the applicant received the notice of denial. If the order is issued
15.17 through the provider hub, the appeal must be received by the commissioner within 20
15.18 calendar days from the date the commissioner issued the order through the hub. Section
15.19 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

15.20 Sec. 11. Minnesota Statutes 2024, section 245D.081, subdivision 3, is amended to read:

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

15.25 (1) maintaining a current understanding of the licensing requirements sufficient to ensure
15.26 compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph
15.27 (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~
15.28 256B.044, subdivision 8;

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

15.31 (3) ensuring the program implements corrective action identified as necessary by the
15.32 program following review of incident and emergency reports according to the requirements
15.33 in section 245D.11, subdivision 2, clause (7). An internal review of incident reports of

16.1 alleged or suspected maltreatment must be conducted according to the requirements in
16.2 section 245A.65, subdivision 1, paragraph (b);

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

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

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

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

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

16.18 Sec. 12. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
16.19 to read:

16.20 Subd. 4a. **Case management contact.** "Case management contact" means interactive
16.21 communication conducted either in person, by interactive video that meets the requirements
16.22 of section 256B.0625, subdivision 20b, or by telephone with the client; client's parent; legal
16.23 guardian, guardian ad litem, or attorney for clients that are children or youth under 19 years
16.24 of age; or client's attorney for clients that are adults 19 years of age or older.

16.25 Sec. 13. Minnesota Statutes 2024, section 256B.04, subdivision 5, is amended to read:

16.26 Subd. 5. **Annual report required.** The state agency within 60 days after the close of
16.27 each fiscal year, shall prepare and print for the fiscal year a report that includes; a full
16.28 account of the operations and expenditure of funds under this chapter; a full account of the
16.29 activities undertaken in accordance with subdivision 10; adequate and complete statistics
16.30 divided by counties about all medical assistance provided in accordance with this chapter;
16.31 a full account of all pre-enrollment, postenrollment, and unannounced site visits to providers
16.32 under section 256B.044, subdivision 5; and any other information it may deem advisable.

17.1 Sec. 14. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended
17.2 to read:

17.3 Subd. 21. **Provider enrollment.** ~~(a)~~ The commissioner shall enroll providers and conduct
17.4 screening activities as required by Code of Federal Regulations, title 42, section 455, subpart
17.5 E, and sections 256B.044 to 256B.0448.

17.6 ~~A provider must enroll each provider-controlled location where direct services are
17.7 provided. The commissioner may deny a provider's incomplete application if a provider
17.8 fails to respond to the commissioner's request for additional information within 60 days of
17.9 the request. The commissioner must conduct a background study under chapter 245C,
17.10 including a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses
17.11 (1) to (5), for a provider described in this paragraph. The background study requirement
17.12 may be satisfied if the commissioner conducted a fingerprint-based background study on
17.13 the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph
17.14 (a), clauses (1) to (5).~~

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

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

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

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

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

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

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

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

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

17.31 ~~(d) If a provider fails to comply with any individual provider requirement or condition
17.32 of participation, the commissioner may suspend the provider's ability to bill until the provider~~

18.1 ~~comes into compliance. The commissioner's decision to suspend the provider is not subject~~
18.2 ~~to an administrative appeal.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19.20 ~~(j) As a condition of enrollment in medical assistance, the commissioner shall require~~
19.21 ~~that a provider designated "moderate" or "high-risk" by the Centers for Medicare and~~
19.22 ~~Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid~~
19.23 ~~Services, its agents, or its designated contractors and the state agency, its agents, or its~~
19.24 ~~designated contractors to conduct unannounced on-site inspections of any provider location.~~
19.25 ~~The commissioner shall publish in the Minnesota Health Care Program Provider Manual a~~
19.26 ~~list of provider types designated "limited," "moderate," or "high-risk," based on the criteria~~
19.27 ~~and standards used to designate Medicare providers in Code of Federal Regulations, title~~
19.28 ~~42, section 424.518. The list and criteria are not subject to the requirements of chapter 14.~~
19.29 ~~The commissioner's designations are not subject to administrative appeal.~~

19.30 ~~(k) As a condition of enrollment in medical assistance, the commissioner shall require~~
19.31 ~~that a high-risk provider, or a person with a direct or indirect ownership interest in the~~
19.32 ~~provider of five percent or higher, consent to criminal background checks, including~~
19.33 ~~fingerprinting, when required to do so under state law or by a determination by the~~

20.1 ~~commissioner or the Centers for Medicare and Medicaid Services that a provider is designated~~
20.2 ~~high-risk for fraud, waste, or abuse.~~

20.3 ~~(1)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable~~
20.4 ~~medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers~~
20.5 ~~meeting the durable medical equipment provider and supplier definition in clause (3),~~
20.6 ~~operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is~~
20.7 ~~annually renewed and designates the Minnesota Department of Human Services as the~~
20.8 ~~obligee, and must be submitted in a form approved by the commissioner. For purposes of~~
20.9 ~~this clause, the following medical suppliers are not required to obtain a surety bond: a~~
20.10 ~~federally-qualified health center, a home health agency, the Indian Health Service, a~~
20.11 ~~pharmacy, and a rural health clinic.~~

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

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

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

21.1 ~~maintains a surety bond under the requirements in section 256B.051, 256B.0659, 256B.0701,~~
21.2 ~~or 256B.85.~~

21.3 Sec. 15. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision
21.4 to read:

21.5 Subd. 28. **Medical assistance education program.** (a) The commissioner must provide
21.6 information to all medical assistance enrollees on the following topics:

21.7 (1) an enrollee's benefits, rights, and responsibilities under medical assistance;

21.8 (2) how to appropriately access and receive services under medical assistance;

21.9 (3) an enrollee's right to file complaints, grievances, and appeals;

21.10 (4) general information about preventing fraud and abuse in the medical assistance
21.11 program; and

21.12 (5) how to report concerns to the department and managed care organizations about
21.13 fraud and abuse in the medical assistance program.

21.14 (b) The commissioner must ensure that the information provided under this subdivision:

21.15 (1) is in plain language;

21.16 (2) is culturally and linguistically appropriate; and

21.17 (3) complies with applicable federal Medicaid requirements for communicating with
21.18 enrollees.

21.19 (c) When an enrollee's use of medical assistance results in abusive or fraudulent billing,
21.20 the commissioner must notify the enrollee about the availability of the information under
21.21 this subdivision and may provide additional educational information targeted to the event
21.22 that resulted in abusive or fraudulent billing.

21.23 (d) The commissioner may require entities participating in medical assistance, including
21.24 but not limited to managed care organizations, providers, lead agencies, and Tribal agencies,
21.25 to assist in delivering the information required under this subdivision.

21.26 (e) For enrollees who receive case management services or have a support plan developed
21.27 under section 256B.0911, the information required under this subdivision must be tailored
21.28 to their service needs and may be delivered through the support planning process by the
21.29 lead agency or managed care organization, as appropriate.

22.1 Sec. 16. [256B.044] PROVIDER ENROLLMENT.

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

22.7 (b) The list and criteria are not subject to the requirements under chapter 14 and section
22.8 14.386 does not apply.

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

22.10 Subd. 2. Required verifications and checks. The commissioner must perform the
22.11 following verifications and checks prior to making an enrollment determination and
22.12 periodically thereafter:

22.13 (1) verify that the provider meets applicable federal and state requirements for the
22.14 provider type;

22.15 (2) conduct license verifications, as applicable, including verification of current licensure
22.16 in Minnesota and in any other state in which the provider is or was previously licensed, in
22.17 accordance with Code of Federal Regulations, title 42, section 455.412;

22.18 (3) conduct database checks on a pre-enrollment and postenrollment basis to ensure that
22.19 the provider continues to meet the enrollment criteria for the provider type, in accordance
22.20 with Code of Federal Regulations, title 42, section 455.436;

22.21 (4) confirm that the provider and any disclosed owners, managing employees, or
22.22 controlling individuals are not excluded from participation in any state's Medicaid program,
22.23 Medicare, or any other federal health care program;

22.24 (5) verify the provider's National Provider Identifier and, as applicable, Medicare
22.25 enrollment status;

22.26 (6) verify the provider's tax identification number and business registration status;

22.27 (7) verify the provider's ownership and control disclosures as required under federal
22.28 law; and

22.29 (8) conduct any additional screenings, verifications, or reviews that are necessary to
22.30 protect the integrity of the medical assistance program or that are required under federal
22.31 law.

23.1 Subd. 3. **Required background studies.** (a) The commissioner must conduct a
23.2 background study under chapter 245C for a provider applying for enrollment. The background
23.3 study must include a review of databases in section 245C.08, subdivision 1, paragraph (a),
23.4 clauses (1) to (5), and any other databases required under federal law.

23.5 (b) The commissioner must conduct a background study under this subdivision for each
23.6 individual with an ownership or control interest in, or who is an officer, director, agent,
23.7 managing employee, or other person with operational or managerial control of, the provider.

23.8 (c) Fingerprint-based studies are required when mandated by federal law or when a
23.9 provider is designated moderate-risk or high-risk under subdivision 1.

23.10 (d) The commissioner may conduct background studies postenrollment as necessary.

23.11 (e) A provider's failure to submit to the commissioner the information required for a
23.12 background study under this subdivision is grounds for denial or termination of enrollment
23.13 in medical assistance.

23.14 (f) A provider's enrollment must be denied or terminated if a provider or individual
23.15 subject to a background study under this subdivision is disqualified under chapter 245C or
23.16 is excluded from participating in any federal health care programs.

23.17 Subd. 4. **Service location enrollment.** (a) A provider must enroll each provider-controlled
23.18 location where direct services are provided. "Provider-controlled location" means a physical
23.19 site owned, leased, operated, or otherwise controlled by the provider.

23.20 (b) Separate enrollment is not required for services provided in a recipient's home or
23.21 community setting, telehealth services delivered from an enrolled site, compliant mobile
23.22 services, or other federally permissible exemptions.

23.23 (c) A provider's failure to enroll each provider-controlled location where direct services
23.24 are provided is grounds for sanctions under section 256B.064.

23.25 Subd. 5. **Site visits.** (a) As a condition of enrollment in medical assistance, the
23.26 commissioner shall require that a provider permit the Centers for Medicare and Medicaid
23.27 Services (CMS), CMS's agents, or CMS's designated contractors and the Department of
23.28 Human Services (DHS), DHS's agents, or DHS's designated contractors to conduct
23.29 unannounced site visits of any of a provider's enrolled locations.

23.30 (b) At a minimum, the commissioner must conduct the following site visits at each of
23.31 a provider's enrolled locations:

24.1 (1) pre-enrollment site visits for providers designated as moderate-risk or high-risk under
24.2 subdivision 1;

24.3 (2) postenrollment site visits for providers designated as moderate-risk or high-risk under
24.4 subdivision 1; and

24.5 (3) unannounced site visits, as follows:

24.6 (i) prior to payment of the provider's first claim after enrollment, when required under
24.7 federal law or due to program integrity concerns;

24.8 (ii) within 12 months after the provider begins to bill claims; and

24.9 (iii) prior to revalidation under section 256B.0441, subdivision 3.

24.10 (c) The commissioner may conduct additional announced or unannounced site visits
24.11 when necessary to verify compliance with enrollment requirements or to protect program
24.12 integrity.

24.13 (d) A provider's failure to permit a required site visit is grounds for denial, suspension,
24.14 or termination of enrollment and may result in denial of claims or recoupment of payments.

24.15 Subd. 6. **Surety bonds.** (a) The commissioner must require a provider to purchase a
24.16 surety bond as a condition of initial enrollment, reenrollment, revalidation, reinstatement,
24.17 or continued enrollment. Upon new enrollment, or if the provider's medical assistance
24.18 revenue in the previous calendar year is less than or equal to \$300,000, the provider must
24.19 purchase a surety bond of \$50,000. If the provider's medical assistance revenue in the
24.20 previous calendar year is greater than \$300,000, the provider must purchase a surety bond
24.21 of \$100,000. The surety bond must name DHS as an obligee and must allow for recovery
24.22 of costs and fees in pursuing a claim on the bond.

24.23 (b) This subdivision does not apply if the provider currently maintains a surety bond
24.24 under the requirements under section 256B.0659, 256B.0701, or 256B.85.

24.25 Subd. 7. **Financial capacity.** As a condition of enrolling in medical assistance, the
24.26 commissioner must require, in a form and manner prescribed by the commissioner, that a
24.27 provider demonstrate sufficient financial capacity to operate and repay improper payments
24.28 for 30 days.

24.29 Subd. 8. **Compliance programs.** (a) The commissioner may require, as a condition of
24.30 enrollment in medical assistance, that a provider in a particular industry, of a particular
24.31 provider type, or with a particular risk categorization under subdivision 1, establish and
24.32 maintain a compliance program consistent with federal program integrity guidance issued

25.1 by CMS or the United States Department of Health and Human Services Office of Inspector
25.2 General.

25.3 (b) If an enrolled provider is required by the commissioner or by federal or state law to
25.4 designate an individual as the provider's compliance officer, the provider must appoint an
25.5 individual responsible for implementing and overseeing the compliance program.

25.6 (c) At a minimum, the compliance program must include policies and procedures designed
25.7 to:

25.8 (1) ensure adherence to federal and state laws and program requirements governing
25.9 medical assistance and prevent the submission of improper claims;

25.10 (2) train employees, agents, contractors, and subcontractors, including billing personnel,
25.11 on applicable federal and state laws and program requirements;

25.12 (3) establish procedures for receiving, investigating, and responding to allegations of
25.13 improper conduct and for implementing corrective actions;

25.14 (4) use auditing, monitoring, or other evaluation techniques to assess ongoing compliance;

25.15 (5) promptly report to the commissioner any credible evidence of violations of federal
25.16 and state laws or regulations governing medical assistance; and

25.17 (6) report and return identified medical assistance overpayments within 60 days after
25.18 discovery or by the date any corresponding cost report is due, whichever is later, in
25.19 accordance with federal law.

25.20 Subd. 9. **Incomplete provider enrollment applications.** The commissioner must deny
25.21 a provider's incomplete enrollment application if a provider fails to respond to the
25.22 commissioner's request for additional information within 60 days of the request.

25.23 Subd. 10. **Correspondence and notification.** The commissioner must deliver
25.24 correspondence and notifications, including notifications of termination and other actions,
25.25 electronically to a provider's MN-ITS mailbox. This subdivision does not apply to
25.26 correspondences and notifications related to background studies.

25.27 Sec. 17. **[256B.0441] PROVIDER REVALIDATION.**

25.28 Subdivision 1. **Requirement.** The commissioner must revalidate each enrolled provider
25.29 according to this section.

25.30 Subd. 2. **Schedule.** (a) The commissioner shall revalidate:

25.31 (1) each provider at least once every five years;

26.1 (2) each personal care assistance agency, community first services and supports (CFSS)
26.2 provider-agency, and CFSS financial management services provider at least once every
26.3 three years;

26.4 (3) each EIDBI agency at least once every three years; and

26.5 (4) each medical-assistance-only provider type the commissioner deems high-risk under
26.6 section 256B.044, subdivision 1, at least every three years.

26.7 (b) The commissioner must conduct revalidation of a provider more frequently when
26.8 required under federal law or when necessary to protect program integrity.

26.9 Subd. 3. **Procedures.** (a) The commissioner shall conduct revalidation as follows:

26.10 (1) provide 30 days' notice to the provider of the provider's revalidation due date,
26.11 including instructions for revalidation, a list of materials the provider must submit, and a
26.12 notice about the unannounced site visit required under paragraph (b);

26.13 (2) if a provider fails to submit all required materials or satisfy the requirements of
26.14 paragraph (b) by the due date, notify the provider of the deficiency within 14 days after the
26.15 due date and allow the provider an additional 14 days from the notification date to comply;
26.16 and

26.17 (3) if a provider fails to remedy a deficiency within the additional 28-day time period,
26.18 give 15 days' notice of termination and immediately suspend the provider's ability to bill.
26.19 The commissioner's decision to suspend the provider's ability to bill is not subject to an
26.20 administrative appeal.

26.21 (b) The commissioner must conduct unannounced site visits at each of a provider's
26.22 enrolled locations under section 256B.044, subdivision 4, no more than 30 days prior to the
26.23 provider's revalidation due date.

26.24 (c) A provider must demonstrate financial capacity, as described under section 256B.044,
26.25 subdivision 7, as a requirement of revalidation under this subdivision.

26.26 Sec. 18. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**
26.27 **TERMINATIONS.**

26.28 Subdivision 1. **Suspension of billing privileges.** (a) If a provider fails to comply with
26.29 any individual provider requirement or condition of participation, the commissioner must
26.30 suspend the provider's ability to bill until the provider comes into compliance.

27.1 (b) Notwithstanding any law to the contrary, the commissioner may immediately impose
27.2 a suspension under this subdivision when necessary to protect public funds or ensure program
27.3 integrity.

27.4 (c) A suspension under this subdivision does not limit the authority of the commissioner
27.5 to issue any other sanction authorized under federal or state law.

27.6 (d) The commissioner's decision to suspend a provider's ability to bill is not subject to
27.7 an administrative appeal.

27.8 **Subd. 2. Revocation for lack of documentation.** (a) The commissioner may revoke
27.9 the enrollment of an ordering or rendering provider for a period of not more than one year
27.10 if the provider fails to maintain and, upon request from the commissioner, provide access
27.11 to documentation relating to written orders or requests for payment for durable medical
27.12 equipment, certifications for home health services, or referrals for other items or services
27.13 written or ordered by the provider when the commissioner has identified a pattern of a lack
27.14 of documentation. A pattern means a failure to maintain documentation or provide access
27.15 to documentation on more than one occasion.

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

27.18 **Subd. 3. Mandatory denial or termination of enrollment.** (a) The commissioner must
27.19 terminate or deny the enrollment of a provider when:

27.20 (1) an individual with a five percent or greater direct or indirect ownership interest in
27.21 the provider does not submit timely and accurate information and cooperate with the
27.22 screening methods required under section 256B.044;

27.23 (2) an individual with a five percent or greater direct or indirect ownership interest in
27.24 the provider has been convicted of a criminal offense related to the individual's involvement
27.25 in Medicare, Medicaid, or the Children's Health Insurance Program in the last ten years,
27.26 unless the commissioner determines that denial or termination of enrollment is not in the
27.27 best interests of the medical assistance program and the commissioner documents that
27.28 determination in writing;

27.29 (3) the provider, or an individual with a five percent or greater direct or indirect ownership
27.30 interest in the provider, was terminated from participation in Medicare on or after January
27.31 1, 2011, or under a Medicaid program or Children's Health Insurance Program of any other
27.32 state, and is currently included in the termination database under Code of Federal Regulations,
27.33 title 42, section 455.417, except as provided in paragraph (b);

28.1 (4) the provider, or an individual with a five percent or greater direct or indirect ownership
28.2 interest in the provider, fails to submit timely or accurate information, unless the
28.3 commissioner determines that termination or denial of enrollment is not in the best interests
28.4 of the medical assistance program and the commissioner documents that determination in
28.5 writing;

28.6 (5) the provider, or an individual with a five percent or greater direct or indirect ownership
28.7 interest in the provider, fails to submit sets of fingerprints in a form and manner determined
28.8 by the commissioner within 30 days of a request from the Centers for Medicare and Medicaid
28.9 Services (CMS) or the commissioner, unless the commissioner determines that termination
28.10 or denial of enrollment is not in the best interests of the medical assistance program and the
28.11 commissioner documents that determination in writing;

28.12 (6) the provider fails to permit access to provider locations for any site visits under
28.13 section 256B.044, subdivision 5, unless the commissioner determines that termination or
28.14 denial of enrollment is not in the best interests of the medical assistance program and the
28.15 commissioner documents that determination in writing; or

28.16 (7) CMS or the commissioner determines that the provider has falsified any information
28.17 provided on the application or cannot verify the identity of any provider applicant.

28.18 (b) The commissioner may exempt a rehabilitation agency from termination or denial
28.19 that would otherwise be required under paragraph (a), clause (3), if the agency:

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

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

28.24 (3) serves primarily a pediatric population.

28.25 **Subd. 4. Termination for lack of submitted claims.** The commissioner may terminate
28.26 the enrollment of an individual provider or an entity provider if the individual provider or
28.27 entity provider has not submitted any claims in the previous 12 consecutive calendar months.

28.28 **Sec. 19. [256B.0443] PROVIDER PAYMENT WITHHOLDS.**

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

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

29.3 Sec. 20. **[256B.0444] ENROLLMENT MORATORIUM FOR HIGH-RISK**
29.4 **PROVIDERS.**

29.5 Subdivision 1. **Provider enrollment moratorium.** (a) If the commissioner or the Centers
29.6 for Medicare and Medicaid Services (CMS) designates a provider type as high-risk under
29.7 section 256B.044, subdivision 1, the commissioner may issue a statewide or regional
29.8 enrollment moratorium and stop accepting and processing applications from providers
29.9 within that category within 30 days of the date of the designation or upon federal approval
29.10 of the moratorium, whichever is later. A moratorium issued under this section is effective
29.11 for a period of up to 24 months from the date the moratorium is issued.

29.12 (b) Before ending the moratorium under this section, the commissioner must revalidate
29.13 the enrollment of each provider within the affected category in accordance with the
29.14 revalidation procedures under section 256B.0441, subdivision 3.

29.15 Subd. 2. **Moratorium exceptions.** The commissioner may grant exceptions to a
29.16 moratorium issued under subdivision 1 and must make publicly available the processes and
29.17 criteria the commissioner will use to grant exceptions. The commissioner may grant an
29.18 exception if a county or Tribal agency submits a request for an exception to the commissioner
29.19 and the commissioner determines that the agency's request sufficiently shows that enrollment
29.20 of the new provider:

29.21 (1) is essential to meet regional needs;

29.22 (2) addresses a specific population to be served; or

29.23 (3) fulfills a need that cannot otherwise be met by existing enrolled providers.

29.24 Subd. 3. **Continued enrollment of new clients.** Nothing in this section prohibits an
29.25 enrolled provider subject to a moratorium under this section from enrolling new clients or
29.26 beneficiaries during the period of the enrollment moratorium.

29.27 Subd. 4. **Notice.** At least ten days prior to issuing an enrollment moratorium under this
29.28 section, the commissioner must notify enrolled providers within the affected category and
29.29 the chairs and ranking minority members of the legislative committees with jurisdiction
29.30 over health and human services about the actions the commissioner plans to take under this
29.31 section. The notice must:

29.32 (1) include a list of provider types to which the moratorium applies;

30.1 (2) provide a general explanation for the basis of the high-risk designation; and

30.2 (3) identify the start dates and anticipated durations of the enrollment moratorium.

30.3 Subd. 5. **Report to legislature.** Within 60 days of ending an enrollment moratorium
30.4 under this section, the commissioner must submit a report to the chairs and ranking minority
30.5 members of the legislative committees with jurisdiction over health and human services.

30.6 The report must include, at a minimum:

30.7 (1) a summary of any sanctions imposed under section 256B.064 on any providers subject
30.8 to the moratorium; and

30.9 (2) recommendations for modifying or terminating the provision of covered services
30.10 delivered by provider types subject to the moratorium.

30.11 Sec. 21. **[256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
30.12 **FOR SPECIFIC PROVIDER TYPES.**

30.13 Subdivision 1. **Durable medical equipment provider or supplier.** (a) For the purposes
30.14 of this subdivision, "durable medical equipment provider or supplier" means a medical
30.15 supplier that can purchase medical equipment or supplies for sale or rent to the general
30.16 public and is able to perform or arrange for necessary repairs to and maintenance of
30.17 equipment offered for sale or rent.

30.18 (b) Upon initial enrollment, reenrollment, and notification of revalidation, all durable
30.19 medical equipment, prosthetics, orthotics, and supplies medical suppliers meeting the durable
30.20 medical equipment provider or supplier definition in paragraph (a), operating in Minnesota,
30.21 and receiving medical assistance money must purchase a surety bond that is annually
30.22 renewed, designates the state agency as the obligee, and is submitted in a form approved
30.23 by the commissioner. For purposes of this paragraph, the following medical suppliers are
30.24 not required to obtain a surety bond: a federally qualified health center, a home health
30.25 agency, the Indian Health Service, a pharmacy, and a rural health clinic.

30.26 (c) At the time of initial enrollment or reenrollment, durable medical equipment providers
30.27 or suppliers as defined in paragraph (a) must purchase a surety bond of \$50,000. If a
30.28 revalidating provider's medical assistance revenue in the previous calendar year is up to and
30.29 including \$300,000, the provider agency must purchase a surety bond of \$50,000. If a
30.30 revalidating provider's medical assistance revenue in the previous calendar year is over
30.31 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
30.32 must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to
30.33 obtain monetary recovery or sanctions from a surety bond must occur within six years from

31.1 the date the debt is affirmed by a final agency decision. An agency decision is final when
31.2 the right to appeal the debt has been exhausted or the time to appeal has expired under
31.3 section 256B.064.

31.4 Subd. 2. **Providers licensed by the commissioner of human services.** An enrolled
31.5 provider that is licensed by the commissioner under chapter 245A must designate an
31.6 individual as the licensee's compliance officer under section 256B.044, subdivision 8,
31.7 paragraph (b).

31.8 Subd. 3. **Providers licensed by the commissioner of health.** An enrolled provider that
31.9 is licensed by the commissioner of health as a home care provider under chapter 144A with
31.10 a home and community-based services designation under section 144A.484 on the home
31.11 care license, or as an assisted living facility under chapter 144G, must designate an individual
31.12 as the licensee's compliance officer under section 256B.044, subdivision 8, paragraph (b).

31.13 Sec. 22. **[256B.0446] ADDITIONAL PROVIDER ENROLLMENT TRAINING**
31.14 **REQUIREMENTS FOR HIGH-RISK PROVIDERS.**

31.15 Subdivision 1. **Applicability.** This section applies to any agency that provides a service
31.16 designated by the commissioner as high-risk under section 256B.044, subdivision 1. For
31.17 purposes of this section, "agency" means the legal entity that is applying to be or is enrolled
31.18 with Minnesota health care programs as a medical assistance provider according to Minnesota
31.19 Rules, part 9505.0195.

31.20 Subd. 2. **Mandatory compliance training.** (a) Effective January 1, 2027, before applying
31.21 for enrollment or reenrollment as a medical assistance provider, an agency applying to
31.22 provide services designated by the commissioner as high-risk under section 256B.044,
31.23 subdivision 1, must require all owners of the agency who are active in the day-to-day
31.24 management and operations of the agency and all managerial and supervisory employees
31.25 to complete compliance training. All individuals required to complete training under this
31.26 subdivision must repeat the training prior to the agency's revalidation as a medical assistance
31.27 provider.

31.28 (b) New owners active in day-to-day management and operations of the agency and new
31.29 managerial and supervisory employees of the agency must complete compliance training
31.30 under this subdivision within 30 calendar days of becoming an owner of or beginning
31.31 employment with the agency and prior to conducting any management or operations activities
31.32 for the agency. If an individual moves to another agency providing the same service and
31.33 serves in a similar ownership or employment capacity, the individual is not required to
31.34 repeat the training required under this subdivision. If the individual does not repeat the

32.1 compliance training, the individual must provide documentation to the agency that proves
32.2 that the individual completed the compliance training within the provider revalidation
32.3 schedule for the relevant provider type as determined by the commissioner under section
32.4 256B.0441, subdivisions 2 and 3.

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

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

32.9 (2) enrollment requirements;

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

32.11 (4) fair labor standards;

32.12 (5) workplace safety requirements; and

32.13 (6) recent changes in service requirements.

32.14 **Sec. 23. [256B.0447] ENHANCED PREPAYMENT REVIEW.**

32.15 Subdivision 1. **Purpose and authority.** The commissioner must conduct enhanced
32.16 prepayment review of submitted fee-for-service medical assistance claims to ensure
32.17 compliance with state and federal law and prevent improper payments before payment.

32.18 Subd. 2. **Providers, services, and claims subject to review.** (a) The commissioner must
32.19 conduct enhanced prepayment review under this section when:

32.20 (1) the commissioner or the Centers for Medicare and Medicaid Services designates a
32.21 provider type as moderate-risk or high-risk under section 256B.044, subdivision 1, for
32.22 fee-for-service claims submitted by providers within that category;

32.23 (2) the commissioner or the Centers for Medicare and Medicaid Services designates a
32.24 covered service as high-risk, for fee-for-service claims submitted for that service by any
32.25 provider, except the Indian Health Service; or

32.26 (3) a provider enrolls in medical assistance for the first time.

32.27 (b) The commissioner may place any other provider, provider type, covered service, or
32.28 category of fee-for-service claims under enhanced prepayment review when the commissioner
32.29 determines there is a risk of improper payment.

33.1 (c) Nothing in this section prevents the commissioner from establishing enhanced
33.2 prepayment review in other circumstances if required by the Centers for Medicare and
33.3 Medicaid Services.

33.4 Subd. 3. **Review requirements.** (a) The commissioner must implement an enhanced
33.5 prepayment review established under this section within 15 days of a provider, covered
33.6 service, or fee-for-service claim being subject to review under subdivision 2.

33.7 (b) Before ending enhanced prepayment review under subdivision 2, paragraph (a),
33.8 clause (1) or (2), the commissioner must review the fee-for-service claims submitted during
33.9 the period the provider type or covered service was subject to the enhanced prepayment
33.10 review and determine whether continuation of the review is warranted.

33.11 Subd. 4. **Notice.** (a) Except as provided in paragraph (b), the commissioner must provide
33.12 written notice to a provider placed under enhanced prepayment review at least 15 days
33.13 before the review is implemented. The notice must include:

33.14 (1) the basis for the review;

33.15 (2) the effective date of the review; and

33.16 (3) the standards the commissioner will use to determine when the provider, covered
33.17 service, or claims will no longer be subject to enhanced prepayment review.

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

33.21 (c) At least 15 days before implementing an enhanced prepayment review, the
33.22 commissioner must notify the chairs and ranking minority members of the legislative
33.23 committees with jurisdiction over health and human services policy and finance about the
33.24 enhanced prepayment review the commissioner plans to implement under this section. The
33.25 notice must include:

33.26 (1) the basis for the review;

33.27 (2) the effective date of the review;

33.28 (3) the providers, provider types, covered services, or categories of fee-for-service claims
33.29 to which enhanced prepayment review applies;

33.30 (4) the anticipated duration of the enhanced prepayment review; and

33.31 (5) the standards the commissioner will use to determine when the provider, service, or
33.32 claims will no longer be subject to enhanced prepayment review.

34.1 Subd. 5. Continued enrollment of new clients. Nothing in this section prohibits an
34.2 enrolled provider that is subject to enhanced prepayment review from enrolling new clients
34.3 or beneficiaries during the period of review unless otherwise prohibited by law or by a
34.4 separate action of the commissioner.

34.5 Subd. 6. Timely claims processing. The commissioner must administer enhanced
34.6 prepayment review in a manner consistent with Code of Federal Regulations, title 42, section
34.7 447.45.

34.8 Subd. 7. Duration and termination. (a) Enhanced prepayment review must continue
34.9 for 24 consecutive months unless:

34.10 (1) the commissioner determines that earlier termination is appropriate based on sustained
34.11 compliance; or

34.12 (2) the commissioner has initiated sanction, suspension, termination, or other enforcement
34.13 action arising out of the review and that action remains pending on appeal, in which case
34.14 the enhanced prepayment review may continue until final disposition of the enforcement
34.15 action.

34.16 (b) Fee-for-service claims for services provided during the period of enhanced prepayment
34.17 review remain subject to review before payment regardless of when the claims are submitted.

34.18 Subd. 8. Relationship to other actions. Enhanced prepayment review under this section
34.19 does not preclude the commissioner from conducting a preliminary investigation, full
34.20 investigation, payment suspension, postpayment review, audit, overpayment recovery,
34.21 sanction, or referral to law enforcement under this chapter or under applicable federal law.

34.22 Subd. 9. Report to legislature. (a) Within 60 days after ending an enhanced prepayment
34.23 review under this section, the commissioner must submit a report to the chairs and ranking
34.24 minority members of the legislative committees with jurisdiction over health and human
34.25 services policy and finance. The report must include, at a minimum:

34.26 (1) a list of providers, provider types, covered services, or categories of claims subject
34.27 to review;

34.28 (2) the duration of the review;

34.29 (3) aggregate outcomes, including claim denials, payments delayed, and referrals for
34.30 further action; and

34.31 (4) recommendations for statutory, administrative, or systems changes.

34.32 (b) Notwithstanding section 256.01, subdivision 42, this subdivision does not expire.

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

35.2 Sec. 24. **[256B.0448] POSTPAYMENT REVIEW.**

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

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

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

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

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

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

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

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

35.28 Sec. 25. **[256B.045] RECIPIENT PROTECTIONS AND CONTINUITY OF CARE**
35.29 **WHEN A PROVIDER IS SUBJECT TO A SERIOUS OPERATIONAL EVENT.**

35.30 Subdivision 1. **Definitions.** (a) For purposes of sections 256B.045 to 256B.047, the
35.31 following terms have the meanings given.

36.1 (b) "Complex transition" means a provider termination, suspension, revocation, or closure
36.2 event that, without structured transition measures, would likely result in avoidable
36.3 hospitalization, institutionalization, serious clinical deterioration, or loss of housing or
36.4 placement for a recipient.

36.5 (c) "Direct recipient care costs" means costs necessary to furnish covered services,
36.6 excluding owner distributions, dividends, related party profit, and other noncare financial
36.7 transfers.

36.8 (d) "Lead agency" means a county, Tribe, or managed care organization.

36.9 (e) "Recipient" means an enrollee, participant, resident, or other individual receiving
36.10 services under medical assistance.

36.11 (f) "Serious operational event" means sanctions or termination actions affecting provider
36.12 participation or payments under section 256B.064, licensure loss or revocation, insolvency,
36.13 receivership, bankruptcy, abandonment, or inability of a provider to safely operate.

36.14 Subd. 2. **Provider duties.** If a medical assistance service provider determines it is unable
36.15 to continue to provide services to a recipient due to a serious operational event, the provider
36.16 must:

36.17 (1) when practicable, notify each recipient; each recipient's responsible party, if
36.18 applicable; the lead agency; and the commissioner 30 days before terminating services to
36.19 each recipient;

36.20 (2) assist the commissioner and lead agency in supporting each recipient in transitioning
36.21 to another provider of each recipient's choice; and

36.22 (3) when practicable, provide each recipient with a copy of the relevant recipient bill of
36.23 rights or recipient protections, if applicable, at least 30 days before terminating services.

36.24 Subd. 3. **Commissioner's duties.** (a) When a provider is subject to a serious operational
36.25 event, the commissioner or the commissioner's designee must:

36.26 (1) inform the appropriate ombudsperson's office, if applicable, and the lead agency for
36.27 each recipient currently receiving services; and

36.28 (2) directly notify each recipient who receives services from the provider in order to
36.29 protect recipient welfare.

36.30 (b) When a medical assistance service provider provides notice to the commissioner
36.31 under subdivision 2 that it is unable to continue to provide services to a recipient due to a

37.1 serious operational event, the commissioner must assist the provider and the lead agency
37.2 in supporting the recipient in transitioning to another provider of the recipient's choice.

37.3 (c) The commissioner must ensure each recipient receives continuity of medically
37.4 necessary services and supports through a safe and orderly transition to appropriate receiving
37.5 providers when a serious operational event is designated as a complex transition under
37.6 section 256B.046.

37.7 Subd. 4. **Lead agency duties.** When a provider is subject to a serious operational event,
37.8 a lead agency must contact affected service recipients to ensure that each recipient:

37.9 (1) is continuing to receive needed services; and

37.10 (2) has been given free choice of provider if the recipient transfers to another service
37.11 provider.

37.12 Sec. 26. **[256B.046] COMPLEX TRANSITIONS.**

37.13 Subdivision 1. **Complex transition designation.** (a) The commissioner must designate
37.14 a serious operational event as a complex transition when:

37.15 (1) a recipient is receiving long-term services and supports, including home and
37.16 community-based services;

37.17 (2) a recipient is receiving behavioral health or substance use disorder treatment where
37.18 abrupt interruption of treatment creates a material risk;

37.19 (3) a recipient is medically fragile and depends on life-sustaining treatment;

37.20 (4) there is limited regional capacity, including limited culturally or linguistically
37.21 appropriate care; or

37.22 (5) a recipient's placement stability is dependent upon continued service delivery.

37.23 (b) The commissioner may establish objective thresholds to create a presumption of
37.24 complex transition based on the number of recipients affected by a serious operational event,
37.25 recipient acuity, service type, or unresolved discharge or placement barriers.

37.26 Subd. 2. **Complex transition operations plan.** The commissioner must develop and
37.27 implement a written complex transition operations plan for each complex transition. The
37.28 plan must include:

37.29 (1) recipient identification and acuity level;

37.30 (2) stabilization actions to prevent gaps in care for high-risk recipients;

- 38.1 (3) medical record, medication, and treatment plan continuity procedures;
38.2 (4) receiving provider identification and capacity information;
38.3 (5) transition timelines, transportation, and handoff procedures;
38.4 (6) the communication plan for each recipient, the recipient's family, and the recipient's
38.5 guardian, if applicable, including language access; and
38.6 (7) coordination with lead agencies, case managers, and ombudsperson offices, when
38.7 applicable.

38.8 Subd. 3. **Complex transition team.** The commissioner may convene a complex transition
38.9 team that includes department staff, lead agencies, and other professionals, as necessary,
38.10 to ensure the safe transition of recipients from the provider that is unable to continue to
38.11 provide services to another provider.

38.12 Subd. 4. **Complex transition; legislative notice.** The commissioner must notify the
38.13 chairs and ranking minority members of the legislative committees with jurisdiction over
38.14 human services policy and finance within ten days of designating a complex transition and
38.15 must provide a report within 90 days of recipient stabilization to identify systemic gaps and
38.16 make recommendations for systemic improvements.

38.17 Sec. 27. **[256B.047] CONTINUITY PERIOD AND TRANSITION PAYMENTS FOR**
38.18 **COMPLEX TRANSITIONS.**

38.19 Subdivision 1. **Limited continuity period.** A provider subject to a serious operational
38.20 event that is designated as a complex transition under section 256B.046 may continue to
38.21 provide services to high-risk recipients receiving long-term services and supports or hospice
38.22 care for up to 180 days after the date the serious operational event was designated a complex
38.23 transition. The continuity period under this subdivision does not reinstate provider
38.24 participation in medical assistance and does not limit the commissioner's sanction, exclusion,
38.25 recovery, licensing enforcement, or referral authority.

38.26 Subd. 2. **Good cause payment safeguards.** When payment withholds or reductions
38.27 occur under section 256B.064, the commissioner may find good cause not to suspend
38.28 payments under Code of Federal Regulations, title 42, section 455.23(e) or (f), in order to
38.29 provide for continuity of care during complex transitions.

38.30 Subd. 3. **Transition payments.** (a) If the commissioner does not suspend payments to
38.31 a provider sanctioned under section 256B.064 due to a determination of good cause, payments
38.32 to the provider must be limited to direct recipient care costs. A provider receiving payments

39.1 under this section must submit to independent financial monitoring and a prohibition on
39.2 financial distributions to owners.

39.3 (b) The commissioner shall prioritize payment to alternative enrolled medical assistance
39.4 providers that assume responsibility for service provision, court-appointed receivers or
39.5 interim managers providing services, or substitute providers operating on site under an
39.6 approved complex transition operations plan.

39.7 (c) When permitted by state and federal law, the amount of allowable transition payments
39.8 paid to a provider under this section is subtracted from the debts the provider owes to the
39.9 state.

39.10 (d) Nothing in this section requires payments that are prohibited by federal law.

39.11 Sec. 28. Minnesota Statutes 2025 Supplement, section 256B.051, subdivision 6, is amended
39.12 to read:

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

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

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

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

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

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

40.1 right to appeal the debt has been exhausted or the time to appeal has expired under section
40.2 256B.064;

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

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

40.7 (8) completes compliance training as required under section 256B.0446, subdivision ~~6b~~
40.8 2.

40.9 Sec. 29. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 20, is
40.10 amended to read:

40.11 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the
40.12 state agency, medical assistance covers case management services to persons with serious
40.13 and persistent mental illness and children with serious mental illness. Services provided
40.14 under this section must meet the relevant standards in sections 245.461 to 245.4887, the
40.15 Comprehensive Adult and Children's Mental Health Acts, Minnesota Rules, parts 9520.0900
40.16 to 9520.0926, and 9505.0322, excluding subpart 10.

40.17 (b) Entities meeting program standards set out in rules governing family community
40.18 support services as defined in section 245.4871, subdivision 17, are eligible for medical
40.19 assistance reimbursement for case management services for children with serious mental
40.20 illness when these services meet the program standards in Minnesota Rules, parts 9520.0900
40.21 to 9520.0926, and 9505.0322, ~~excluding subparts 6 and 10~~ subpart 9.

40.22 (c) Medical assistance and MinnesotaCare payment for mental health case management
40.23 ~~shall~~ must be made ~~on a monthly basis~~ in accordance with section 256B.076, subdivisions
40.24 1, 2, 5, and 7. ~~In order to receive payment for an eligible child, the provider must document~~
40.25 ~~at least a face-to-face contact either in person or by interactive video that meets the~~
40.26 ~~requirements of subdivision 20b with the child, the child's parents, or the child's legal~~
40.27 ~~representative. To receive payment for an eligible adult, the provider must document:~~

40.28 ~~(1) at least a face-to-face contact with the adult or the adult's legal representative either~~
40.29 ~~in person or by interactive video that meets the requirements of subdivision 20b; or~~

40.30 ~~(2) at least a telephone contact with the adult or the adult's legal representative and~~
40.31 ~~document a face-to-face contact either in person or by interactive video that meets the~~
40.32 ~~requirements of subdivision 20b with the adult or the adult's legal representative within the~~
40.33 ~~preceding two months.~~

41.1 (d) Payment for mental health case management provided by county or state staff shall
41.2 must be based on the monthly rate methodology under section 256B.094, subdivision 6,
41.3 paragraph (b), with separate rates calculated for child welfare and mental health, and within
41.4 mental health, separate rates for children and adults 256B.076, subdivisions 5 and 7.

41.5 (e) Payment for mental health case management provided by Indian health services or
41.6 by agencies operated by Indian tribes may be made according to this section or other relevant
41.7 federally approved rate setting methodology.

41.8 (f) Payment for mental health case management provided by vendors who contract with
41.9 a county must be calculated in accordance with section 256B.076, subdivision 2. Payment
41.10 for mental health case management provided by vendors who contract with a Tribe must
41.11 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
41.12 by the vendor for the same service to other payers. If the service is provided by a team of
41.13 contracted vendors, the team shall determine how to distribute the rate among its members.
41.14 No reimbursement received by contracted vendors shall be returned to the county or tribe,
41.15 except to reimburse the county or tribe for advance funding provided by the county or tribe
41.16 to the vendor.

41.17 (g) If the service is provided by a team which includes contracted vendors, tribal staff,
41.18 and county or state staff, the costs for county or state staff participation in the team shall be
41.19 included in the rate for county-provided services. In this case, the contracted vendor, the
41.20 tribal agency, and the county may each receive separate payment for services provided by
41.21 each entity in the same month. In order to prevent duplication of services, each entity must
41.22 document, in the recipient's file, the need for team case management and a description of
41.23 the roles of the team members.

41.24 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
41.25 mental health case management shall be provided by the recipient's county of responsibility,
41.26 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
41.27 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal
41.28 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state
41.29 without a federal share through fee-for-service, 50 percent of the cost shall be provided by
41.30 the recipient's county of responsibility.

41.31 (i) Notwithstanding any administrative rule to the contrary, prepaid medical assistance
41.32 and MinnesotaCare include mental health case management. When the service is provided
41.33 through prepaid capitation, the nonfederal share is paid by the state and the county pays no
41.34 share.

42.1 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
42.2 that does not meet the ~~reporting or other~~ requirements of this section or sections 245.4711,
42.3 245.4881, 256B.0924, 256B.094, and 256F.10. The county of responsibility, as defined in
42.4 sections 256G.01 to 256G.12, or, if applicable, the tribal agency, is responsible for any
42.5 federal disallowances. The county or tribe may share this responsibility with its contracted
42.6 vendors.

42.7 (k) The commissioner shall set aside a portion of the federal funds earned for county
42.8 expenditures under this section to repay the special revenue maximization account under
42.9 section 256.01, subdivision 2, paragraph (n). The repayment is limited to:

42.10 (1) the costs of developing and implementing this section; and

42.11 (2) programming the information systems.

42.12 (l) Payments to counties and tribal agencies for case management expenditures under
42.13 this section shall only be made from federal earnings from services provided under this
42.14 section. When this service is paid by the state without a federal share through fee-for-service,
42.15 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors
42.16 shall include the federal earnings, the state share, and the county share.

42.17 (m) Case management services under this subdivision do not include therapy, treatment,
42.18 legal, or outreach services.

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

42.22 (1) the last 180 days of the recipient's residency in that facility and may not exceed more
42.23 than six months in a calendar year; or

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

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

42.27 (p) If the recipient is receiving care in a hospital, nursing facility, or residential setting
42.28 licensed under chapter 245A or 245D that is staffed 24 hours a day, seven days a week,
42.29 mental health targeted case management services must actively support identification of
42.30 community alternatives for the recipient and discharge planning.

42.31 (q) Counties may receive payment for up to 12 15-minute units for use at case initiation
42.32 and case closing to facilitate the case management client's needs assessments, individualized

43.1 plan development, referrals, or case documentation without needing to meet the contact
43.2 requirements specified in sections 245.4711, 245.4881, 256B.0924, 256B.094, and 256F.10.

43.3 Sec. 30. Minnesota Statutes 2024, section 256B.064, subdivision 1b, is amended to read:

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

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

43.9 (2) withholding payments to an individual or entity;

43.10 (3) suspending participation in the program;

43.11 (4) terminating participation in the program; or

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

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

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

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

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

43.24 Sec. 31. Minnesota Statutes 2024, section 256B.064, subdivision 1c, is amended to read:

43.25 Subd. 1c. **Grounds for and methods of monetary recovery.** (a) The commissioner
43.26 may obtain monetary recovery from an individual or entity that has been improperly paid
43.27 by the department either as a result of conduct described in subdivision 1a or as a result of
43.28 an error by the individual or entity submitting the claim or by the department, regardless of
43.29 whether the error was intentional. Patterns need not be proven as a precondition to monetary
43.30 recovery of erroneous or false claims, duplicate claims, claims for services not medically
43.31 necessary, or claims based on false statements.

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

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

44.9 Sec. 32. Minnesota Statutes 2024, section 256B.064, subdivision 1d, is amended to read:

44.10 Subd. 1d. **Investigative costs.** (a) The commissioner may seek recovery of investigative
 44.11 costs from any individual or entity that willfully submits a claim for reimbursement for
 44.12 services that the individual or entity knows, or reasonably should have known, is a false
 44.13 representation and that results in the payment of public funds for which the individual or
 44.14 entity is ineligible.

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

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

44.18 Sec. 33. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

44.19 Subd. 2. **Imposition of monetary recovery and sanctions; generally.** (a) The
 44.20 commissioner ~~shall~~ must determine any monetary amounts to be recovered and sanctions
 44.21 to be imposed upon an individual or entity under this section. Except as provided in
 44.22 ~~paragraphs (b) and (d), neither~~ subdivisions 2b to 2d, the commissioner must not obtain a
 44.23 monetary recovery ~~nor~~ or impose a sanction ~~will be imposed by the commissioner~~ without
 44.24 prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's
 44.25 proposed action, ~~provided that the commissioner may suspend or reduce payment to an~~
 44.26 ~~individual or entity, except a nursing home or convalescent care facility, after notice and~~
 44.27 ~~prior to the hearing if in the commissioner's opinion that action is necessary to protect the~~
 44.28 ~~public welfare and the interests of the program.~~

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

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

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

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

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

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

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

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

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

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

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

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

45.25 ~~(d) The withholding or reduction of payments will not continue after the commissioner~~
45.26 ~~determines there is insufficient evidence of fraud by the individual or entity, or after legal~~
45.27 ~~proceedings relating to the alleged fraud are completed, unless the commissioner has sent~~
45.28 ~~notice of intention to impose monetary recovery or sanctions under paragraph (a). Upon~~
45.29 ~~conviction for a crime related to the provision, management, or administration of a health~~
45.30 ~~service under medical assistance, a payment held pursuant to this section by the commissioner~~
45.31 ~~or a managed care organization that contracts with the commissioner under section 256B.035~~

46.1 ~~is forfeited to the commissioner or managed care organization, regardless of the amount~~
46.2 ~~charged in the criminal complaint or the amount of criminal restitution ordered.~~

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

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

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

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

46.13 ~~(f) (b) Upon receipt of a notice under paragraph (a) or subdivision 2c that a monetary~~
46.14 ~~recovery or sanction is to be imposed, an individual or entity may request a contested case,~~
46.15 ~~as defined in section 14.02, subdivision 3, by filing with the commissioner a written request~~
46.16 ~~of appeal. The appeal request must be received by the commissioner no later than 30 days~~
46.17 ~~after the date the notification of monetary recovery or sanction was mailed to the individual~~
46.18 ~~or entity. The appeal request must specify:~~

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

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

46.22 ~~(3) the authority in statute or rule upon which the individual or entity relies for each~~
46.23 ~~disputed item;~~

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

46.26 ~~(5) other information required by the commissioner.~~

46.27 ~~(g) The commissioner may order an individual or entity to forfeit a fine for failure to~~
46.28 ~~fully document services according to standards in this chapter and Minnesota Rules, chapter~~
46.29 ~~9505. The commissioner may assess fines if specific required components of documentation~~
46.30 ~~are missing. The fine for incomplete documentation shall equal 20 percent of the amount~~
46.31 ~~paid on the claims for reimbursement submitted by the individual or entity, or up to \$5,000,~~
46.32 ~~whichever is less. If the commissioner determines that an individual or entity repeatedly~~

47.1 ~~violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to~~
47.2 ~~the provision of services to program recipients and the submission of claims for payment,~~
47.3 ~~the commissioner may order an individual or entity to forfeit a fine based on the nature,~~
47.4 ~~severity, and chronicity of the violations, in an amount of up to \$5,000 or 20 percent of the~~
47.5 ~~value of the claims, whichever is greater.~~

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

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

47.11 Sec. 34. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
47.12 to read:

47.13 Subd. 2a. **Imposition of fines.** (a) The commissioner may order an individual or entity
47.14 to forfeit a fine for failure to fully document services according to standards under this
47.15 chapter and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific
47.16 required components of documentation are missing. The fine for incomplete documentation
47.17 equals 20 percent of the amount paid on the claims for reimbursement submitted by the
47.18 individual or entity or up to \$5,000, whichever is less. If the commissioner determines that
47.19 an individual or entity repeatedly violated this chapter, chapter 245G or 254B, or Minnesota
47.20 Rules, chapter 9505, related to the provision of services to program recipients and the
47.21 submission of claims for payment, the commissioner may order an individual or entity to
47.22 forfeit a fine based on the nature, severity, and chronicity of the violations in an amount of
47.23 up to \$5,000 or 20 percent of the value of the claims, whichever is greater.

47.24 (b) The individual or entity must pay the fine assessed on or before the payment date
47.25 specified by the commissioner. If the individual or entity fails to pay the fine, the
47.26 commissioner may withhold or reduce payments and recover the amount of the fine. A
47.27 timely appeal stays payment of the fine until the commissioner issues a final order.

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

47.29 Sec. 35. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
47.30 to read:

47.31 Subd. 2b. **Mandatory suspension or termination after exclusion from participation**
47.32 **in Medicare.** (a) The commissioner must suspend or terminate an individual's or entity's

48.1 participation in the program without providing advance notice and an opportunity for a
48.2 hearing when the suspension or termination is required because of the individual's or entity's
48.3 exclusion from participation in Medicare.

48.4 (b) Within five days of taking an action under paragraph (a), the commissioner must
48.5 send notice of the suspension or termination to the individual or entity. The notice must:

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

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

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

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

48.12 Sec. 36. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
48.13 to read:

48.14 **Subd. 2c. Imposition of withholding or reduction of payments before a hearing.** (a)
48.15 Except as provided in paragraph (b), the commissioner may withhold or reduce payment
48.16 to an individual or entity after notice but before a hearing if, in the commissioner's opinion,
48.17 withholding or reducing payment is necessary to protect the public welfare and the interests
48.18 of the program.

48.19 (b) The commissioner must not withhold or reduce payments to a nursing home or
48.20 convalescent care facility before a hearing.

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

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

48.24 **Subd. 2d. Imposition of withholding or reduction of payments without prior**
48.25 **notice.** (a) Except when the commissioner finds good cause not to suspend payments under
48.26 Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner must
48.27 withhold or reduce payments to an individual or entity without providing advance notice
48.28 of the withholding or reduction if either of the following occurs:

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

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

49.7 (i) fraud hotline complaints;

49.8 (ii) claims data mining;

49.9 (iii) patterns identified through provider audits, civil false claims cases, and law
49.10 enforcement investigations; and

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

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

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

49.17 (2) set forth the general allegations as to the nature of the withholding or reduction action
49.18 but need not disclose any specific information concerning an ongoing investigation;

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

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

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

49.25 (c) The commissioner must cease the withholding or reduction of payments under this
49.26 subdivision after the commissioner determines there is insufficient evidence of fraud by the
49.27 individual or entity or after legal proceedings relating to the alleged fraud are completed,
49.28 unless the commissioner has sent notice of intention to impose monetary recovery or
49.29 sanctions.

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

50.1 Sec. 38. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
50.2 to read:

50.3 Subd. 2e. **Forfeiture of withheld payments upon criminal conviction.** Upon conviction
50.4 for a crime related to the provision, management, or administration of a health service under
50.5 medical assistance, a payment held pursuant to this section by the commissioner or a managed
50.6 care organization that contracts with the commissioner under section 256B.035 is forfeited
50.7 to the commissioner or managed care organization, regardless of the amount charged in the
50.8 criminal complaint or the amount of criminal restitution ordered.

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

50.10 Sec. 39. Minnesota Statutes 2024, section 256B.064, subdivision 3, is amended to read:

50.11 Subd. 3. **Mandates on prohibited payments.** (a) The commissioner ~~shall~~ must maintain
50.12 and publish a list of each excluded individual and entity that was convicted of a crime related
50.13 to the provision, management, or administration of a medical assistance health service, or
50.14 suspended or terminated under subdivision ~~2~~ 2b. Medical assistance payments cannot be
50.15 made by an individual or entity for items or services furnished either directly or indirectly
50.16 by an excluded individual or entity, or at the direction of excluded individuals or entities.

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

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

50.25 (d) An entity that pays medical assistance program funds to an individual or entity on
50.26 the exclusion list must refund any payment related to either items or services rendered by
50.27 an individual or entity on the exclusion list from the date the individual or entity is first paid
50.28 or the date the individual or entity is placed on the exclusion list, whichever is later, and an
50.29 entity may be subject to:

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

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

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

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

51.3 Sec. 40. Minnesota Statutes 2024, section 256B.064, subdivision 4, is amended to read:

51.4 Subd. 4. **Notice.** (a) The department ~~shall~~ must serve the notice required under ~~subdivision~~
51.5 subdivisions 2 and 2d using a signature-verified confirmed delivery method to the address
51.6 submitted to the department by the individual or entity. Service is complete upon mailing.

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

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

51.14 Sec. 41. Minnesota Statutes 2024, section 256B.064, subdivision 5, is amended to read:

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

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

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

51.25 (d) After an investigation is complete, the reporter's name must be kept confidential.
51.26 The subject of the report may compel disclosure of the reporter's name only with the consent
51.27 of the reporter or upon a written finding by a district court that the report was false and there
51.28 is evidence that the report was made in bad faith. This subdivision does not alter disclosure
51.29 responsibilities or obligations under the Rules of Criminal Procedure, except that when the
51.30 identity of the reporter is relevant to a criminal prosecution the district court ~~shall~~ must
51.31 conduct an in-camera review before determining whether to order disclosure of the reporter's
51.32 identity.

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

52.2 Sec. 42. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
52.3 to read:

52.4 Subd. 6. **Suspension, withholding, or reduction of payments; administrative**
52.5 **review.** (a) An individual or entity that is subject to a temporary withholding or reduction
52.6 of payments under subdivision 2d, paragraph (a), clause (2), may request an administrative
52.7 review before the state Court of Administrative Hearings within ten business days of
52.8 receiving notice of the withholding or reduction of payments. The commissioner must refer
52.9 the matter to the Court of Administrative Hearings within five business days of receiving
52.10 the request for administrative review.

52.11 (b) The Court of Administrative Hearings must conduct an expedited hearing within 30
52.12 days after the commissioner refers the matter to the court.

52.13 (c) In an administrative review under this subdivision, the administrative law judge must
52.14 determine:

52.15 (1) whether the commissioner has demonstrated, by a preponderance of the evidence,
52.16 that a credible allegation of fraud exists; and

52.17 (2) whether continuing the temporary withholding or reduction of payments is reasonable
52.18 and necessary to protect the integrity of the medical assistance program.

52.19 (d) The administrative law judge must issue a recommendation within ten days following
52.20 the hearing. The administrative law judge must recommend upholding the temporary
52.21 withholding or reduction of payments only if the commissioner demonstrates, by a
52.22 preponderance of the evidence, that a credible allegation of fraud exists and that payment
52.23 withholding or reduction is appropriate under applicable federal Medicaid program integrity
52.24 requirements.

52.25 (e) Within ten days after receiving the administrative law judge's recommendation, the
52.26 commissioner must issue a final determination affirming, modifying, or ceasing the temporary
52.27 withholding or reduction of payments.

52.28 (f) If the administrative law judge determines that withholding the full amount of
52.29 payments would jeopardize access to medically necessary services for medical assistance
52.30 recipients, the commissioner may modify the withholding to allow partial payments for the
52.31 duration of an investigation.

53.1 Sec. 43. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
53.2 to read:

53.3 Subd. 7. **Periodic review of withholding or reduction of payments** (a) The
53.4 commissioner must review any temporary payment withholding or reduction under
53.5 subdivision 2d, paragraph (a), clause (2), at least every 90 days to determine whether the
53.6 credible allegation of fraud continues to necessitate the withholding or reduction of payments.

53.7 (b) If a payment withholding or reduction remains in effect for 180 days or more, the
53.8 commissioner must provide a written status report on the specific withholding or reduction
53.9 to the chairs and ranking minority members of the legislative committees with jurisdiction
53.10 over human services. The report must summarize the status of the investigation, specify the
53.11 basis for continuing the withholding or reduction, and indicate any anticipated timeline for
53.12 resolution. The commissioner may withhold any information that would compromise an
53.13 ongoing criminal investigation from the report required under this paragraph.

53.14 Sec. 44. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
53.15 to read:

53.16 Subd. 8. **Coordination with law enforcement.** When a temporary withholding or
53.17 reduction of payments under subdivision 2d, paragraph (a), clause (2), involves potential
53.18 criminal conduct, the commissioner must coordinate with appropriate law enforcement
53.19 authorities, including the Minnesota attorney general's Medicaid Fraud Control Unit, and
53.20 may consult with state or federal investigative agencies as necessary. The commissioner
53.21 may delay notice or disclosure of specific investigative information to the individual or
53.22 entity being investigated when law enforcement certifies that disclosure would compromise
53.23 an ongoing criminal investigation.

53.24 Sec. 45. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
53.25 to read:

53.26 Subd. 9. **Application.** This section supersedes any inconsistent or contrary provision of
53.27 law.

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

53.29 Sec. 46. **[256B.0647] REMITTANCE ADVICE MONETARY RECOVERY.**

53.30 (a) The commissioner may use the remittance advice process under Code of Federal
53.31 Regulations, title 45, part 162.1601, as the notice to a vendor or provider when seeking
53.32 monetary recovery using a department-administered information technology system for

54.1 programmatically processed claims. The remittance advice must be delivered electronically
54.2 and constitutes the sole notice to the provider. The commissioner must withhold the payments
54.3 at issue when using the remittance advice as the notice.

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

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

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

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

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

54.17 (5) other information required by the commissioner.

54.18 Sec. 47. Minnesota Statutes 2024, section 256B.0651, subdivision 17, is amended to read:

54.19 Subd. 17. **Recipient protection.** ~~(a) Providers of home care services must provide each~~
54.20 ~~recipient with a copy of the home care bill of rights under section 144A.44 at least 30 days~~
54.21 ~~prior to terminating services to a recipient, if the termination results from provider sanctions~~
54.22 ~~under section 256B.064, such as a payment withhold, a suspension of participation, or a~~
54.23 ~~termination of participation. If a home care provider determines it is unable to continue~~
54.24 ~~providing services to a recipient, the provider must notify the recipient, the recipient's~~
54.25 ~~responsible party, and the commissioner 30 days prior to terminating services to the recipient~~
54.26 ~~because of an action under section 256B.064, and must assist the commissioner and lead~~
54.27 ~~agency in supporting the recipient in transitioning to another home care provider of the~~
54.28 ~~recipient's choice~~ meet the recipient protection requirements under section 256B.045 when
54.29 subject to a serious operational event as defined in section 256B.045, subdivision 1.

54.30 ~~(b) In the event of a payment withhold from a home care provider, a suspension of~~
54.31 ~~participation, or a termination of participation of a home care provider under section~~
54.32 ~~256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care~~
54.33 ~~and the lead agencies for all recipients with active service agreements with the provider. At~~

55.1 ~~the commissioner's request, the lead agencies must contact recipients to ensure that the~~
55.2 ~~recipients are continuing to receive needed care, and that the recipients have been given~~
55.3 ~~free choice of provider if they transfer to another home care provider. In addition, the~~
55.4 ~~commissioner or the commissioner's delegate may directly notify recipients who receive~~
55.5 ~~care from the provider that payments have been or will be withheld or that the provider's~~
55.6 ~~participation in medical assistance has been or will be suspended or terminated, if the~~
55.7 ~~commissioner determines that notification is necessary to protect the welfare of the recipients.~~
55.8 ~~For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care~~
55.9 ~~organizations.~~

55.10 Sec. 48. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is
55.11 amended to read:

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

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

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

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

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

55.22 (5) provides at the time of enrollment, reenrollment, and revalidation in a format
55.23 determined by the commissioner, proof of surety bond coverage for each business location
55.24 providing services. Upon new enrollment, or if the provider's medical assistance revenue
55.25 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety
55.26 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over
55.27 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
55.28 must be in a form approved by the commissioner, must be renewed annually, and must
55.29 allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain
55.30 monetary recovery or sanctions from a surety bond must occur within six years from the
55.31 date the debt is affirmed by a final agency decision. An agency decision is final when the
55.32 right to appeal the debt has been exhausted or the time to appeal has expired under section
55.33 256B.064;

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

56.3 (7) completes compliance training as required under section 256B.0446, subdivision ~~11~~
56.4 2; and

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

56.6 Sec. 49. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is
56.7 amended to read:

56.8 **Subd. 4. Provider payment rates.** (a) Payment rates for participating providers must
56.9 be increased for services provided to medical assistance enrollees. To receive a rate increase,
56.10 participating providers must meet demonstration project requirements and provide evidence
56.11 of formal referral arrangements with providers delivering step-up or step-down levels of
56.12 care. Providers that have enrolled in the demonstration project but have not met the provider
56.13 standards under subdivision 3 as of July 1, 2022, are not eligible for a rate increase under
56.14 this subdivision until the date that the provider meets the provider standards in subdivision
56.15 3. Services provided from July 1, 2022, to the date that the provider meets the provider
56.16 standards under subdivision 3 shall be reimbursed at rates according to section 254B.0505,
56.17 subdivision 1. Rate increases paid under this subdivision to a provider for services provided
56.18 between July 1, 2021, and July 1, 2022, are not subject to recoupment when the provider
56.19 is taking meaningful steps to meet demonstration project requirements that are not otherwise
56.20 required by law, and the provider provides documentation to the commissioner, upon request,
56.21 of the steps being taken.

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

56.26 (c) For outpatient individual and group substance use disorder services under section
56.27 254B.0505, subdivision 1, clause (1), and adolescent treatment programs that are licensed
56.28 as outpatient treatment programs according to sections 245G.01 to 245G.18, provided on
56.29 or after January 1, 2021, payment rates must be increased by 20 percent over the rates in
56.30 effect on December 31, 2020.

56.31 (d) Effective January 1, 2021, and contingent on annual federal approval, managed care
56.32 plans and county-based purchasing plans must reimburse providers of the substance use
56.33 disorder services meeting the criteria described in paragraph (a) who are employed by or

57.1 under contract with the plan an amount that is at least equal to the fee-for-service base rate
57.2 payment for the substance use disorder services described in paragraph (c). The commissioner
57.3 must monitor the effect of this requirement on the rate of access to substance use disorder
57.4 services and residential substance use disorder rates. Capitation rates paid to managed care
57.5 organizations and county-based purchasing plans must reflect the impact of this requirement.
57.6 This paragraph expires if federal approval is not received at any time as required under this
57.7 paragraph.

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

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

57.19 Sec. 50. Minnesota Statutes 2024, section 256B.076, subdivision 1, is amended to read:

57.20 Subdivision 1. **Generally.** (a) It is the policy of this state to ensure that individuals on
57.21 medical assistance receive cost-effective and coordinated care, including efforts to address
57.22 the profound effects of housing instability, food insecurity, and other social determinants
57.23 of health. Therefore, subject to federal approval, medical assistance covers targeted case
57.24 management services as described in this section and sections 245.4711, 245.4881,
57.25 256B.0625, subdivisions 20 to 20b, 256B.0924, 256B.094, and 256F.10.

57.26 (b) The commissioner, in collaboration with Tribes, counties, providers, and individuals
57.27 served, must propose further modifications to targeted case management services to ensure
57.28 a program that complies with all federal requirements, delivers services in a cost-effective
57.29 and efficient manner, creates uniform expectations for targeted case management services,
57.30 addresses health disparities, and promotes person- and family-centered services.

57.31 (c) The commissioner may suspend, reduce, or terminate the reimbursement to a provider
57.32 that does not meet the requirements of this section or sections 245.4711, 245.4881,
57.33 256B.0625, subdivisions 20 and 20b, 256B.0924, 256B.094, and 256F.10. The county of
57.34 financial responsibility, as determined under sections 256G.01 to 256G.12 or, if applicable,

58.1 the Tribal agency, is responsible for any federal disallowances. The county or Tribal agency
58.2 may share the financial responsibility with the county's or Tribal agency's contracted vendors.

58.3 Sec. 51. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
58.4 to read:

58.5 Subd. 5. **County-provided fee-for-service rate setting and reconciliation.** (a) Effective
58.6 January 1 of the implementation year determined under subdivision 6, or upon federal
58.7 approval, whichever is later, the commissioner must pay targeted case management services
58.8 for which counties provide the nonfederal share of money and county staff provide the
58.9 services on a fee-for-service basis according to the cost-based payment methodology in this
58.10 subdivision and consistent with the federal regulations related to certified public expenditures.
58.11 To receive federal reimbursement for these services, a county providing eligible forms of
58.12 targeted case management services must complete a federally approved cost report, in
58.13 accordance with section 256.01, subdivision 2, paragraph (o).

58.14 (b) The commissioner must reimburse submitted claims based on an interim rate and
58.15 must determine a final rate on a calendar-year basis following completion of a cost report
58.16 reconciliation. The commissioner must notify counties of the final rate and post final rates
58.17 publicly.

58.18 (c) A county has 60 days to appeal a final rate. To appeal a final rate, a county must
58.19 submit a written appeal request to the commissioner within 60 days of the date the
58.20 commissioner issued the final rate determination. The appeal request shall specify (1) the
58.21 disputed items, and (2) the name and address of the person to contact regarding the appeal.

58.22 (d) The payment methodology under this section must only be used to reimburse
58.23 allowable Medicaid costs. The county of financial responsibility, as determined under
58.24 sections 256G.01 to 256G.12, is responsible for any federal disallowances.

58.25 (e) Upon implementation, the commissioner must base interim rates on data from the
58.26 testing period. The commissioner must base subsequent interim rates for a calendar year
58.27 on the most recently completed reconciliation. The commissioner must notify counties of
58.28 the interim rate by June 30 each year and post interim rates publicly. If the commissioner
58.29 is unable to notify the counties by June 30, the commissioner must notify each county in
58.30 writing no later than June 30 that the new interim rate is delayed and must provide an
58.31 estimate of when the new interim rate will be available.

58.32 (f) Payments to counties for case management expenditures under this section must be
58.33 made only from federal earnings from services provided under this section.

59.1 (g) Counties must submit all claims for targeted case management services described
59.2 in this section using a 15-minute unit.

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

59.4 Sec. 52. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
59.5 to read:

59.6 Subd. 6. **Testing and implementation.** The commissioners of human services and
59.7 children, youth, and families; the Association of Minnesota Counties (AMC); and the
59.8 Minnesota Association of County Social Service Administrators (MACSSA) must collaborate
59.9 to establish a joint governance agreement that must:

59.10 (1) establish system functionality requirements to meet the business needs of local
59.11 agencies providing targeted case management services and comply with applicable state
59.12 and federal regulations for the Social Services Information System (SSIS), SSIS's
59.13 replacement, and adjacent systems and the target case management cost report under
59.14 subdivision 5;

59.15 (2) establish a schedule for transition planning, including but not limited to fiscal impact
59.16 assessment and training; and

59.17 (3) specify that the rate method established in subdivision 5 must not be implemented
59.18 without both the completion of the required testing period of 12 calendar months and the
59.19 expressed approval by the commissioners of human services and children, youth, and
59.20 families; AMC; and MACSSA.

59.21 Sec. 53. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
59.22 to read:

59.23 Subd. 7. **Managed care plan units and rates for mental health targeted case**
59.24 **management.** The commissioner must ensure that the prepaid health plans providing covered
59.25 health services for eligible persons pursuant to this chapter and chapter 256L reimburse
59.26 counties at a rate that is at least equal to the fee-for-service rate described in subdivision 5
59.27 for targeted case management services provided to Minnesota health care program (MHCP)
59.28 health plan enrollees covered by medical assistance. If, for any contract year, federal approval
59.29 is not received for this subdivision, the commissioner must adjust the capitation rates paid
59.30 to managed care plans and county-based purchasing plans for that contract year to reflect
59.31 the removal of this subdivision. Contracts between managed care plans and county-based
59.32 purchasing plans and providers to whom this subdivision applies must allow recovery of

60.1 payments from those providers if capitation rates are adjusted in accordance with this
60.2 subdivision. Payment recoveries must not exceed the amount equal to any increase in rates
60.3 that results from this subdivision. This subdivision expires if federal approval is not received
60.4 for this subdivision at any time. This subdivision does not obligate MHCP health plans to
60.5 contract with counties for the provision of targeted case management services.

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

60.7 Sec. 54. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision
60.8 to read:

60.9 Subd. 8. **Targeted case management gap funding.** (a) For purposes of this subdivision,
60.10 "unacceptable loss" means when a county's finalized amount of targeted case management
60.11 federal reimbursement following the commissioner's reconciliation for a calendar year for
60.12 targeted case management under subdivision 5 is less than 90 percent of the average federal
60.13 reimbursement received by that county during the base calendar years determined in
60.14 paragraph (c).

60.15 (b) The commissioner must pay targeted case management gap funding in the amount
60.16 and time frame specified in paragraph (c) to an individual county for calendar years in which
60.17 the county experiences an unacceptable loss.

60.18 (c) The base calendar years are the three calendar years immediately before the testing
60.19 period of 12 calendar months determined under subdivision 6. In consultation with the
60.20 county that experienced the unacceptable loss, the commissioner must make appropriate
60.21 adjustments to base year amounts as needed to prevent the base amounts from being unduly
60.22 influenced by onetime events, anomalies, or small changes that appear large compared to
60.23 a narrow historical base. The commissioner must not make adjustments to the eight county
60.24 human services agencies that received the greatest amount of targeted case management
60.25 federal reimbursement during the base calendar years. For agencies other than the eight
60.26 county human services agencies that received the greatest amount, the total of all adjustments
60.27 for a given calendar year must not exceed two percent of statewide federal targeted case
60.28 management federal reimbursement that calendar year.

60.29 (d) The commissioner must pay targeted case management gap funding to the applicable
60.30 county in an amount equaling the difference between the finalized amount of targeted case
60.31 management federal reimbursement after reconciliation for that calendar year and 90 percent
60.32 of the average federal reimbursement received by that county during the base calendar years,
60.33 including any adjustments under paragraph (c). The commissioner must pay the county
60.34 within 90 days of completing the reconciliation under subdivision 5.

61.1 (e) Targeted case management gap funding is a forecasted program under section 16A.11.

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

61.3 Sec. 55. Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, is
61.4 amended to read:

61.5 **Subd. 6. Payment for targeted case management.** ~~(a) Medical assistance and~~
61.6 ~~MinnesotaCare payment for targeted case management shall be made on a monthly basis.~~
61.7 ~~In order to receive payment for an eligible adult, The provider must document at least one~~
61.8 ~~contact per month and not more than two consecutive months without a face-to-face meet~~
61.9 ~~the contact either in person or requirements under section 256B.094, subdivision 6. Contact~~
61.10 ~~by interactive video that meets must meet the requirements in section 256B.0625, subdivision~~
61.11 ~~20b, with the adult or the adult's legal representative, family, primary caregiver, or other~~
61.12 ~~relevant persons person identified as necessary to the development or implementation of~~
61.13 ~~the goals of the personal service plan.~~

61.14 (b) Except as provided under paragraph (m), payment for targeted case management
61.15 provided by county staff under this subdivision ~~shall~~ must be based on the ~~monthly rate~~
61.16 ~~methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one~~
61.17 ~~combined average rate together with adult mental health case management under section~~
61.18 ~~256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate~~
61.19 ~~for case management under this section shall be the same as the rate for adult mental health~~
61.20 ~~case management in effect as of December 31, 2001 established in section 256B.076,~~
61.21 ~~subdivisions 5 and 7. Billing and payment must identify the recipient's primary population~~
61.22 ~~group to allow tracking of revenues.~~

61.23 (c) Payment for targeted case management provided by county-contracted vendors shall
61.24 be based on a monthly rate calculated in accordance with section 256B.076, subdivision 2.
61.25 The rate must not exceed the rate charged by the vendor for the same service to other payers.
61.26 If the service is provided by a team of contracted vendors, the team shall determine how to
61.27 distribute the rate among its members. No reimbursement received by contracted vendors
61.28 shall be returned to the county, except to reimburse the county for advance funding provided
61.29 by the county to the vendor.

61.30 (d) If the service is provided by a team that includes contracted vendors and county staff,
61.31 the costs for county staff participation on the team shall be included in the rate for
61.32 county-provided services. In this case, the contracted vendor and the county may each
61.33 receive separate payment for services provided by each entity in the same month. In order
61.34 to prevent duplication of services, the county must document, in the recipient's file, the need

62.1 for team targeted case management and a description of the different roles of the team
62.2 members.

62.3 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
62.4 targeted case management shall be provided by the recipient's county of responsibility, as
62.5 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
62.6 used to match other federal funds.

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

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

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

62.17 (i) Notwithstanding section 256B.041, county payments for the cost of case management
62.18 services provided by county staff shall not be made to the commissioner of management
62.19 and budget. For the purposes of targeted case management services provided by county
62.20 staff under this section, the centralized disbursement of payments to counties under section
62.21 256B.041 consists only of federal earnings from services provided under this section.

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

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

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

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

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

62.31 (m) The commissioner may make payments for Tribes according to section 256B.0625,
62.32 subdivision 34, or other relevant federally approved rate setting methodologies for vulnerable

63.1 adult and developmental disability targeted case management provided by Indian health
63.2 services and facilities operated by a Tribe or Tribal organization.

63.3 Sec. 56. Minnesota Statutes 2024, section 256B.094, subdivision 2, is amended to read:

63.4 Subd. 2. **Eligible services.** Services eligible for medical assistance reimbursement
63.5 include:

63.6 (1) assessment of the recipient's need for case management services to gain access to
63.7 available medical, social, educational, economic support, and other related services;

63.8 (2) development, completion, and regular review of a written individual service plan
63.9 based on the assessment of need for case management services to ensure access to available
63.10 medical, social, educational, economic support, and other related services;

63.11 (3) routine contact or other communication with the client, the client's family, primary
63.12 caregiver, legal representative, substitute care provider, service providers, or other relevant
63.13 persons identified as necessary to the development or implementation of the goals of the
63.14 individual service plan, regarding the status of the client, the individual service plan, or the
63.15 goals for the client, exclusive of transportation of the child;

63.16 (4) coordinating referrals for, and the provision of, case management services for the
63.17 client with appropriate service providers, consistent with section 1902(a)(23) of the Social
63.18 Security Act;

63.19 (5) coordinating and monitoring the overall service delivery to ensure quality of services;

63.20 (6) monitoring and evaluating services on a regular basis to ensure appropriateness and
63.21 continued need based on the child's and family's or caregiver's current circumstances;

63.22 (7) completing and maintaining necessary documentation that supports and verifies the
63.23 activities in this subdivision;

63.24 (8) traveling to conduct a visit with the client or other relevant person necessary to the
63.25 development or implementation of the goals of the individual service plan; and

63.26 (9) coordinating with the medical assistance facility discharge planner in the 30-day
63.27 period before the client's discharge into the community. This case management service
63.28 provided to patients or residents in a medical assistance facility is limited to a maximum of
63.29 two 30-day periods per calendar year.

64.1 Sec. 57. Minnesota Statutes 2024, section 256B.094, subdivision 3, is amended to read:

64.2 Subd. 3. **Coordination and provision of services.** (a) In a county or reservation where
64.3 a ~~prepaid medical assistance provider~~ managed care organization (MCO) or county-based
64.4 purchasing (CBP) plan has contracted under section 256B.69 to provide medical and mental
64.5 health services, the case management provider shall coordinate with the ~~prepaid provider~~
64.6 MCO or CBP plan to ensure that all necessary medical and mental health services required
64.7 under the contract are provided to recipients of case management services.

64.8 ~~(b) When the case management provider determines that a prepaid provider is not~~
64.9 ~~providing mental health services as required under the contract, the case management~~
64.10 ~~provider shall assist the recipient to appeal the prepaid provider's denial pursuant to section~~
64.11 ~~256.045, and may make other arrangements for provision of the covered services.~~

64.12 ~~(c) The case management provider may bill the provider of prepaid health care services~~
64.13 ~~for any mental health services provided to a recipient of case management services which~~
64.14 ~~the county or tribal social services arranges for or provides and which are included in the~~
64.15 ~~prepaid provider's contract, and which were determined to be medically necessary as a result~~
64.16 ~~of an appeal pursuant to section 256.045. The prepaid provider must reimburse the mental~~
64.17 ~~health provider, at the prepaid provider's standard rate for that service, for any services~~
64.18 ~~delivered under this subdivision.~~

64.19 ~~(b)~~ Child welfare targeted case management is carved out of Minnesota health care
64.20 programs managed care contracts. The case management provider must assist the recipient
64.21 to ensure access to all medically necessary services listed in section 256B.0625, whether
64.22 delivered on a fee-for-service basis or by an MCO or CBP plan.

64.23 ~~(d)~~ (c) If the county or Tribal social services has not obtained prior authorization for this
64.24 service, or an appeal results in a determination that the services were not medically necessary,
64.25 the county or Tribal social services may not seek reimbursement from the prepaid provider.

64.26 Sec. 58. Minnesota Statutes 2024, section 256B.094, subdivision 6, is amended to read:

64.27 Subd. 6. **Medical assistance reimbursement of case management services.** (a) Medical
64.28 assistance reimbursement for services under this section ~~shall~~ must be made ~~on a monthly~~
64.29 ~~basis~~ in accordance with section 256B.076. Payment is based on face-to-face contacts either
64.30 in person or by interactive video, or telephone contacts between the case manager and the
64.31 client, client's family, primary caregiver, legal representative, or other relevant person
64.32 identified as necessary to the development or implementation of the goals of the individual

65.1 service plan regarding the status of the client, the individual service plan, or the goals for
65.2 the client. These contacts must meet the following requirements:

65.3 (1) there must be a face-to-face contact either in person or by interactive video that meets
65.4 the requirements of section 256B.0625, subdivision 20b, at least once a month except as
65.5 provided in clause (2); and

65.6 (2) for a client placed outside of the county of financial responsibility, or a client served
65.7 by Tribal social services placed outside the reservation, in an excluded time facility under
65.8 section 256G.02, subdivision 6, or through the Interstate Compact for the Placement of
65.9 Children, section 260.93, and the placement in either case is more than 60 miles beyond
65.10 the county or reservation boundaries, there must be at least one contact per month and not
65.11 more than two consecutive months without a face-to-face, in-person contact.

65.12 ~~(b) Except as provided under paragraph (c), the payment rate is established using time~~
65.13 ~~study data on activities of provider service staff and reports required under sections 245.482~~
65.14 ~~and 256.01, subdivision 2, paragraph (e).~~

65.15 ~~(e)~~ (b) Payments for Tribes may be made according to section 256B.0625 or other
65.16 relevant federally approved rate setting methodology for child welfare targeted case
65.17 management provided by Indian health services and facilities operated by a Tribe or Tribal
65.18 organization.

65.19 ~~(d)~~ (c) Payment for case management provided by county contracted vendors must be
65.20 calculated in accordance with section 256B.076, subdivision 2. Payment for case management
65.21 provided by vendors who contract with a Tribe must be based on a monthly rate negotiated
65.22 by the Tribe. The rate must not exceed the rate charged by the vendor for the same service
65.23 to other payers. ~~If the service is provided by a team of contracted vendors, the team shall~~
65.24 ~~determine how to distribute the rate among its members.~~ No reimbursement received by
65.25 contracted vendors shall be returned to the county or Tribal social services, except to
65.26 reimburse the county or Tribal social services for advance funding provided by the county
65.27 or Tribal social services to the vendor.

65.28 ~~(e)~~ (d) If the service is provided by a team that includes contracted vendors and county
65.29 or Tribal social services staff, the costs for county or Tribal social services staff participation
65.30 in the team shall be included in the rate for county or Tribal social services provided services.
65.31 In this case, the contracted vendor and the county or Tribal social services may each receive
65.32 separate payment for services provided by each entity in the same month. To prevent
65.33 duplication of services, each entity must document, in the recipient's file, the need for team
65.34 case management and a description of the roles and services of the team members.

66.1 ~~Separate payment rates may be established for different groups of providers to maximize~~
66.2 ~~reimbursement as determined by the commissioner. The payment rate will be reviewed~~
66.3 ~~annually and revised periodically to be consistent with the most recent time study and other~~
66.4 ~~data. Payment for services will be made upon submission of a valid claim and verification~~
66.5 ~~of proper documentation described in subdivision 7. Federal administrative revenue earned~~
66.6 ~~through the time study, or under paragraph (c), shall be distributed according to earnings,~~
66.7 ~~to counties, reservations, or groups of counties or reservations which have the same payment~~
66.8 ~~rate under this subdivision, and to the group of counties or reservations which are not~~
66.9 ~~certified providers under section 256F.10. The commissioner shall modify the requirements~~
66.10 ~~set out in Minnesota Rules, parts 9550.0300 to 9550.0370, as necessary to accomplish this.~~

66.11 Sec. 59. Minnesota Statutes 2024, section 256B.094, subdivision 7, is amended to read:

66.12 Subd. 7. ~~Documentation for case record and claim~~ Service provision
66.13 requirements. (a) The assessment, case finding, and individual service plan shall be
66.14 maintained in the individual case record under the Data Practices Act, chapter 13.

66.15 (b) Payment is based on face-to-face contacts either in person or by interactive video,
66.16 or on telephone contacts between the case manager and the client, client's family, primary
66.17 caregiver, legal representative, or other relevant person identified as necessary to the
66.18 development or implementation of the goals of the individual service plan regarding the
66.19 status of the client, the individual service plan, or the goals for the client. Contacts must
66.20 meet the following requirements:

66.21 (1) in accordance with section 260C.212, subdivision 4a, and United States Code, title
66.22 42, section 622(b)(17), there must be a face-to-face contact either in person or by interactive
66.23 video that meets the requirements of section 256B.0625, subdivision 20b, at least once a
66.24 month, except as provided in clause (2); and

66.25 (2) for a client placed outside of the county of financial responsibility, or a client served
66.26 by Tribal social services placed outside the reservation, in an excluded time facility under
66.27 section 256G.02, subdivision 6, or according to the Interstate Compact for the Placement
66.28 of Children under section 260.93, and the placement in either case is more than 60 miles
66.29 beyond the county or reservation boundaries, there must be at least one contact per month
66.30 and not more than two consecutive months without a face-to-face, in-person contact.

66.31 (c) The individual service plan must be reviewed at least annually and updated as
66.32 necessary. Each individual case record must maintain documentation of routine, ongoing,
66.33 contacts and services. Each claim must be supported by written documentation in the
66.34 individual case record.

67.1 ~~(b)~~ (d) Each claim must include:

67.2 (1) the name of the recipient;

67.3 (2) the date of the service;

67.4 (3) the name of the provider agency and the person providing service;

67.5 (4) the nature and extent of services; and

67.6 (5) the place of the services.

67.7 Sec. 60. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is
67.8 amended to read:

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

67.11 (1) enroll as a medical assistance Minnesota health care program provider according to
67.12 Minnesota Rules, part 9505.0195, and ~~section 256B.04, subdivision 21,~~ sections 256B.044
67.13 to 256B.0448 and meet all applicable provider standards and requirements;

67.14 (2) designate an individual as the agency's compliance officer who must perform the
67.15 duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision
67.16 8, paragraph (b);

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

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

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

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

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

- 68.1 (8) initiate a background study as required under subdivision 16a;
- 68.2 (9) report maltreatment according to section 626.557 and chapter 260E;
- 68.3 (10) comply with any data requests consistent with the Minnesota Government Data
68.4 Practices Act, sections 256B.064 and 256B.27;
- 68.5 (11) provide training for all agency staff on the requirements and responsibilities listed
68.6 in the Maltreatment of Minors Act, chapter 260E, and the Vulnerable Adult Protection Act,
68.7 section 626.557, including mandated and voluntary reporting, nonretaliation, and the agency's
68.8 policy for all staff on how to report suspected abuse and neglect;
- 68.9 (12) have a written policy to resolve issues collaboratively with the person and the
68.10 person's legal representative when possible. The policy must include a timeline for when
68.11 the person and the person's legal representative will be notified about issues that arise in
68.12 the provision of services;
- 68.13 (13) provide the person's legal representative with prompt notification if the person is
68.14 injured while being served by the agency. An incident report must be completed by the
68.15 agency staff member in charge of the person. A copy of all incident and injury reports must
68.16 remain on file at the agency for at least five years from the report of the incident;
- 68.17 (14) before starting a service, provide the person or the person's legal representative a
68.18 description of the treatment modality that the person shall receive, including the staffing
68.19 certification levels and training of the staff who shall provide a treatment;
- 68.20 (15) provide clinical supervision for a minimum of one hour for every 16 hours of direct
68.21 treatment per person, unless otherwise authorized in the person's individual treatment plan;
68.22 and
- 68.23 (16) provide required EIDBI intervention observation and direction at least once per
68.24 month. Notwithstanding subdivision 13, paragraph (1), required EIDBI intervention
68.25 observation and direction under this clause may be conducted via telehealth provided that
68.26 no more than two consecutive monthly required EIDBI intervention observation and direction
68.27 sessions under this clause are conducted via telehealth.
- 68.28 (b) Upon request of the commissioner, an agency delivering services under this section
68.29 must:
- 68.30 (1) identify the agency's controlling individuals, as defined under section 245A.02,
68.31 subdivision 5a;

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

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

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

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

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

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

69.15 Sec. 61. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

69.16 Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the
69.17 Early Intensive Developmental and Behavioral Intervention Advisory Council and
69.18 stakeholders, including agencies, professionals, parents of people with ASD or a related
69.19 condition, and advocacy organizations, the commissioner shall determine if a shortage of
69.20 EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers"
69.21 means a lack of availability of providers who meet the EIDBI provider qualification
69.22 requirements under subdivision 15 that results in the delay of access to timely services under
69.23 this section, or that significantly impairs the ability of a provider agency to have sufficient
69.24 providers to meet the requirements of this section. The commissioner shall consider
69.25 geographic factors when determining the prevalence of a shortage. The commissioner may
69.26 determine that a shortage exists only in a specific region of the state, multiple regions of
69.27 the state, or statewide. The commissioner shall also consider the availability of various types
69.28 of treatment modalities covered under this section.

69.29 (b) The commissioner, in consultation with the Early Intensive Developmental and
69.30 Behavioral Intervention Advisory Council and stakeholders, must establish processes and
69.31 criteria for granting an exception under this paragraph. The commissioner may grant an
69.32 exception only if the exception would not compromise a person's safety and not diminish
69.33 the effectiveness of the treatment. The commissioner may establish an expiration date for

70.1 an exception granted under this paragraph. The commissioner may grant an exception for
70.2 the following:

70.3 (1) EIDBI provider qualifications under this section;

70.4 (2) medical assistance provider enrollment requirements under ~~section 256B.04,~~
70.5 ~~subdivision 21~~ sections 256B.044 to 256B.0448; or

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

70.7 (c) If the commissioner, in consultation with the Early Intensive Developmental and
70.8 Behavioral Intervention Advisory Council and stakeholders, determines that a shortage no
70.9 longer exists, the commissioner must submit a notice that a shortage no longer exists to the
70.10 chairs and ranking minority members of the senate and the house of representatives
70.11 committees with jurisdiction over health and human services. The commissioner must post
70.12 the notice for public comment for 30 days. The commissioner shall consider public comments
70.13 before submitting to the legislature a request to end the shortage declaration. The
70.14 commissioner shall not declare the shortage of EIDBI providers ended without direction
70.15 from the legislature to declare it ended.

70.16 Sec. 62. Minnesota Statutes 2024, section 256B.198, is amended to read:

70.17 **256B.198 PAYMENTS FOR NON-HOSPITAL-BASED GOVERNMENTAL**
70.18 **HEALTH CENTERS.**

70.19 (a) The commissioner may make payments to non-hospital-based health centers operated
70.20 by a governmental entity for the difference between the expenditures incurred by the health
70.21 center for patients eligible for medical assistance, and the payments to the health center for
70.22 medical assistance permitted elsewhere under this chapter.

70.23 (b) The nonfederal share of payments authorized under paragraph (a) shall be provided
70.24 through certified public expenditures authorized under section 256B.199, paragraph (b).

70.25 (c) Effective July 1, 2013, or no earlier than 12 months after implementation of a total
70.26 cost of care demonstration project, Hennepin County may receive federal matching funds
70.27 for certified public expenditures under paragraph (a), if the county participates in a total
70.28 cost of care demonstration project under sections 256B.0755 and 256B.0756, or another
70.29 total cost of care demonstration project approved by the commissioner, and the county
70.30 exceeds the minimum performance threshold established by the commissioner for the
70.31 demonstration project. The value of the federal matching funds for the certified public
70.32 expenditures allocated to Hennepin County shall be equal to the value of savings achieved
70.33 above the minimum performance threshold. The same proportion of federal matching funds

71.1 for certified public expenditure allocated to Hennepin County based on savings achieved
71.2 under the demonstration project shall continue after the demonstration project and must
71.3 continue to be paid to Hennepin County each year thereafter.

71.4 (d) Beginning July 1, 2014, or no earlier than 12 months after the initial allocation under
71.5 paragraph (c) if a portion of the federal matching funds for certified public expenditure
71.6 remains with the state, the commissioner shall annually determine if the savings from
71.7 county's total cost of care demonstration project exceeded the savings from the previous
71.8 year and allocate federal matching funds for certified public expenditures to Hennepin
71.9 County equal to the amount of savings achieved above the amount achieved in the previous
71.10 year. The proportion of federal matching funds for certified public expenditure allocated to
71.11 Hennepin County shall be paid to Hennepin County each year thereafter, until no federal
71.12 matching funds for certified public expenditures under paragraph (a) remain with the state.

71.13 (e) Nothing under this section precludes Hennepin County from receiving an additional
71.14 gain-sharing payment or relieves the county from paying a downside risk-sharing payment
71.15 to the state under the demonstration project under section 256B.0755.

71.16 (f) Payments under this section expire June 30, 2026.

71.17 Sec. 63. Minnesota Statutes 2024, section 256B.69, subdivision 5a, is amended to read:

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

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

71.27 (c) The commissioner shall withhold five percent of managed care plan payments under
71.28 this section and county-based purchasing plan payments under section 256B.692 for the
71.29 prepaid medical assistance program pending completion of performance targets. Each
71.30 performance target must be quantifiable, objective, measurable, and reasonably attainable,
71.31 except in the case of a performance target based on a federal or state law or rule. Criteria
71.32 for assessment of each performance target must be outlined in writing prior to the contract
71.33 effective date. Clinical or utilization performance targets and their related criteria must

72.1 consider evidence-based research and reasonable interventions when available or applicable
72.2 to the populations served, and must be developed with input from external clinical experts
72.3 and stakeholders, including managed care plans, county-based purchasing plans, and
72.4 providers. The managed care or county-based purchasing plan must demonstrate, to the
72.5 commissioner's satisfaction, that the data submitted regarding attainment of the performance
72.6 target is accurate. The commissioner shall periodically change the administrative measures
72.7 used as performance targets in order to improve plan performance across a broader range
72.8 of administrative services. The performance targets must include measurement of plan
72.9 efforts to contain spending on health care services and administrative activities. The
72.10 commissioner may adopt plan-specific performance targets that take into account factors
72.11 affecting only one plan, including characteristics of the plan's enrollee population. The
72.12 withheld funds must be returned no sooner than July of the following year if performance
72.13 targets in the contract are achieved. The commissioner may exclude special demonstration
72.14 projects under subdivision 23.

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

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

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

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

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

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

73.1 (e) Effective for services rendered on or after January 1, 2013, through December 31,
73.2 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
73.3 this section and county-based purchasing plan payments under section 256B.692 for the
73.4 prepaid medical assistance program. The withheld funds must be returned no sooner than
73.5 July 1 and no later than July 31 of the following year. The commissioner may exclude
73.6 special demonstration projects under subdivision 23.

73.7 (f) Effective for services rendered on or after January 1, 2014, the commissioner shall
73.8 withhold three percent of managed care plan payments under this section and county-based
73.9 purchasing plan payments under section 256B.692 for the prepaid medical assistance
73.10 program. The withheld funds must be returned no sooner than July 1 and no later than July
73.11 31 of the following year. The commissioner may exclude special demonstration projects
73.12 under subdivision 23.

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

73.16 (h) Contracts between the commissioner and a prepaid health plan are exempt from the
73.17 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
73.18 7.

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

73.21 (j) Managed care plans and county-based purchasing plans shall maintain current and
73.22 fully executed agreements for all subcontractors, including bargaining groups, for
73.23 administrative services that are expensed to the state's public health care programs.
73.24 Subcontractor agreements determined to be material, as defined by the commissioner after
73.25 taking into account state contracting and relevant statutory requirements, must be in the
73.26 form of a written instrument or electronic document containing the elements of offer,
73.27 acceptance, consideration, payment terms, scope, duration of the contract, and how the
73.28 subcontractor services relate to state public health care programs. Upon request, the
73.29 commissioner shall have access to all subcontractor documentation under this paragraph.
73.30 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
73.31 to section 13.02.

73.32 (k) The commissioner has the right to recover from a managed care plan the full monetary
73.33 amount of any claims identified as improperly paid during audits or investigations by the

74.1 commissioner or the commissioner's contractors or the Centers for Medicare and Medicaid
74.2 Services.

74.3 Sec. 64. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision
74.4 to read:

74.5 Subd. 38. **Duties when a provider is no longer able to provide services.** When a
74.6 provider is subject to a serious operational event under section 256B.045, managed care
74.7 and county-based purchasing plans must follow the complex transition operations plan
74.8 developed under section 256B.046, honor existing service authorizations when clinically
74.9 appropriate for continuity and safe transfer of services, and ensure timely contracting or
74.10 single-case arrangements to prevent service gaps.

74.11 Sec. 65. Minnesota Statutes 2024, section 256B.85, subdivision 23a, is amended to read:

74.12 Subd. 23a. **Sanctions; information for participants upon termination of services.** (a)
74.13 The commissioner may withhold payment from the provider or suspend or terminate the
74.14 provider enrollment number if the provider fails to comply fully with applicable laws or
74.15 rules. The provider has the right to appeal the decision of the commissioner under section
74.16 256B.064.

74.17 (b) Notwithstanding subdivision 13, paragraph (e), if a participant employer fails to
74.18 comply fully with applicable laws or rules, the commissioner may disenroll the participant
74.19 from the budget model. A participant may appeal in writing to the department under section
74.20 256.045, subdivision 3, to contest the department's decision to disenroll the participant from
74.21 the budget model.

74.22 (c) Agency-providers of CFSS services or FMS providers must ~~provide each participant~~
74.23 ~~with a copy of participant protections in subdivision 20c at least 30 days prior to terminating~~
74.24 ~~services to a participant, if the termination results from sanctions under this subdivision or~~
74.25 ~~section 256B.064, such as a payment withhold or a suspension or termination of the provider~~
74.26 ~~enrollment number. If a CFSS agency provider, FMS provider, or consultation services~~
74.27 ~~provider determines it is unable to continue providing services to a participant because of~~
74.28 ~~an action under this subdivision or section 256B.064, the agency provider, FMS provider,~~
74.29 ~~or consultation services provider must notify the participant, the participant's representative,~~
74.30 ~~and the commissioner 30 days prior to terminating services to the participant, and must~~
74.31 ~~assist the commissioner and lead agency in supporting the participant in transitioning to~~
74.32 ~~another CFSS agency provider, FMS provider, or consultation services provider of the~~

75.1 ~~participant's choice~~ meet the recipient protection requirements under section 256B.045 when
 75.2 subject to a serious operational event as defined in section 256B.045, subdivision 1.

75.3 ~~(d) In the event the commissioner withholds payment from a CFSS agency provider,~~
 75.4 ~~FMS provider, or consultation services provider, or suspends or terminates a provider~~
 75.5 ~~enrollment number of a CFSS agency provider, FMS provider, or consultation services~~
 75.6 ~~provider under this subdivision or section 256B.064, the commissioner may inform the~~
 75.7 ~~Office of Ombudsman for Long-Term Care and the lead agencies for all participants with~~
 75.8 ~~active service agreements with the agency provider, FMS provider, or consultation services~~
 75.9 ~~provider. At the commissioner's request, the lead agencies must contact participants to~~
 75.10 ~~ensure that the participants are continuing to receive needed care, and that the participants~~
 75.11 ~~have been given free choice of agency provider, FMS provider, or consultation services~~
 75.12 ~~provider if they transfer to another CFSS agency provider, FMS provider, or consultation~~
 75.13 ~~services provider. In addition, the commissioner or the commissioner's delegate may directly~~
 75.14 ~~notify participants who receive care from the agency provider, FMS provider, or consultation~~
 75.15 ~~services provider that payments have been or will be withheld or that the provider's~~
 75.16 ~~participation in medical assistance has been or will be suspended or terminated, if the~~
 75.17 ~~commissioner determines that the notification is necessary to protect the welfare of the~~
 75.18 ~~participants.~~

75.19 **Sec. 66. MANDATORY COMPLIANCE TRAINING FOR CURRENTLY**
 75.20 **ENROLLED HIGH-RISK MEDICAL ASSISTANCE PROVIDERS.**

75.21 The owners and employees of any medical assistance provider agency subject to the
 75.22 requirements of Minnesota Statutes, section 256B.0446, subdivision 2, and enrolled before
 75.23 January 1, 2027, must complete initial compliance training by January 1, 2028.

75.24 **Sec. 67. REPEALER.**

75.25 Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 11, is repealed.

75.26 **ARTICLE 2**
 75.27 **DEPARTMENT OF HUMAN SERVICES OFFICE OF INSPECTOR GENERAL**
 75.28 **POLICY**

75.29 Section 1. Minnesota Statutes 2024, section 13A.03, is amended by adding a subdivision
 75.30 to read:

75.31 Subd. 2a. **Exception.** Law enforcement may delay notification under section 13A.02,
 75.32 subdivision 3, or authorize another government authority to delay notification to a customer

76.1 without a court order if law enforcement determines in writing that notification would
 76.2 compromise the integrity of a current and ongoing criminal investigation. The written
 76.3 determination from law enforcement must be renewed every 90 days.

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

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

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

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

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

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

76.17 (1) fraud hotline complaints;

76.18 (2) claims data mining;

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

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

76.23 Allegations are credible when they have an indicium of reliability and the state agency has
 76.24 reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case
 76.25 basis.

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

76.28 (1) a final determination to stop payments;

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

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

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

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

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

77.8 Sec. 3. Minnesota Statutes 2024, section 245.095, subdivision 5, is amended to read:

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

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

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

77.18 (3) the provider is operating after a state or federal agency orders the suspension,
77.19 revocation, or decertification of the provider's license or certification, or if the provider is
77.20 subject to a temporary immediate suspension, regardless of whether the action is under
77.21 appeal; or

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

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

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

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

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

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

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

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

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

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

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

78.13 ~~(d)~~ (c) If the commissioner withholds payments under this subdivision, the provider,
78.14 vendor, individual, associated individual, or associated entity has a right to request
78.15 administrative reconsideration. A request for administrative reconsideration must be made
78.16 in writing, state with specificity the reasons the payment withholding decision is in error,
78.17 and include documents to support the request. Within 60 days from receipt of the request,
78.18 the commissioner shall judiciously review allegations, facts, evidence available to the
78.19 commissioner, and information submitted by the provider, vendor, individual, associated
78.20 individual, or associated entity to determine whether the payment withholding should remain
78.21 in place.

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

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

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

78.30 Sec. 4. Minnesota Statutes 2024, section 245A.07, subdivision 2a, is amended to read:

78.31 Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of
78.32 receipt of the license holder's timely appeal, the commissioner shall request assignment of

79.1 an administrative law judge. The request must include a proposed date, time, and place of
79.2 a hearing. A hearing must be conducted by an administrative law judge within 30 calendar
79.3 days of the request for assignment, unless an extension is requested by either party and
79.4 granted by the administrative law judge for good cause. The commissioner shall issue a
79.5 notice of hearing by certified mail or personal service at least ten working days before the
79.6 hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary
79.7 immediate suspension should remain in effect pending the commissioner's final order under
79.8 section 245A.08, regarding a licensing sanction issued under subdivision 3 following the
79.9 immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the
79.10 burden of proof in expedited hearings under this subdivision ~~shall be limited to~~ is met only
79.11 if the commissioner's demonstration commissioner demonstrates that reasonable cause exists
79.12 to believe that the license holder's or controlling individual's actions or failure to comply
79.13 with applicable law or rule poses, or the actions of other individuals or conditions in the
79.14 program poses an imminent risk of harm to the health, safety, or rights of persons served
79.15 by the program. "Reasonable cause" means there exist specific articulable facts or
79.16 circumstances which provide the commissioner with a reasonable suspicion that there is an
79.17 imminent risk of harm to the health, safety, or rights of persons served by the program.
79.18 When the commissioner has determined there is reasonable cause to order the temporary
79.19 immediate suspension of a license based on a violation of safe sleep requirements, as defined
79.20 in section 245A.1435, the commissioner is not required to demonstrate that an infant died
79.21 or was injured as a result of the safe sleep violations. For suspensions under subdivision 2,
79.22 paragraph (a), clause (2), the burden of proof in expedited hearings under this subdivision
79.23 ~~shall be limited to~~ is met only if the commissioner's demonstration commissioner
79.24 demonstrates by a preponderance of the evidence that, since the license was revoked, the
79.25 license holder committed additional violations of law or rule which may adversely affect
79.26 the health or safety of persons served by the program.

79.27 (b) The administrative law judge shall issue findings of fact, conclusions, and a
79.28 recommendation within ten working days from the date of hearing. The parties shall have
79.29 ten calendar days to submit exceptions to the administrative law judge's report. The record
79.30 shall close at the end of the ten-day period for submission of exceptions. The commissioner's
79.31 final order shall be issued within ten working days from the close of the record. When an
79.32 appeal of a temporary immediate suspension is withdrawn or dismissed, the commissioner
79.33 shall issue a final order affirming the temporary immediate suspension within ten calendar
79.34 days of the commissioner's receipt of the withdrawal or dismissal. Within 90 calendar days
79.35 after an immediate suspension has been issued and the license holder has not submitted a

80.1 timely appeal under subdivision 2, paragraph (b), or within 90 calendar days after a final
80.2 order affirming an immediate suspension, the commissioner shall determine:

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

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

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

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

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

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

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

81.1 Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.07, subdivision 3, is amended
81.2 to read:

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

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

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

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

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

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

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

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

81.24 (b) If the license was suspended or revoked, the notice must inform the license holder
81.25 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
81.26 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
81.27 a license. The appeal of an order suspending or revoking a license must be made in writing
81.28 by certified mail, by personal service, or through the provider licensing and reporting hub.
81.29 If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar
81.30 days after the license holder receives notice that the license has been suspended or revoked.
81.31 If a request is made by personal service, it must be received by the commissioner within
81.32 ten calendar days after the license holder received the order. If the order is issued through
81.33 the provider hub, the appeal must be received by the commissioner within ten calendar days

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

82.6 (c)(1) If the license holder was ordered to pay a fine, the notice must inform the license
82.7 holder of the responsibility for payment of fines and the right to a contested case hearing
82.8 under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an
82.9 order to pay a fine must be made in writing by certified mail, by personal service, or through
82.10 the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent
82.11 to the commissioner within ten calendar days after the license holder receives notice that
82.12 the fine has been ordered. If a request is made by personal service, it must be received by
82.13 the commissioner within ten calendar days after the license holder received the order. If the
82.14 order is issued through the provider hub, the appeal must be received by the commissioner
82.15 within ten calendar days from the date the commissioner issued the order through the hub.

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

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

82.30 (4) Fines shall be assessed as follows:

82.31 (i) the license holder shall forfeit \$1,000 for each determination of maltreatment of a
82.32 child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557
82.33 for which the license holder is determined responsible for the maltreatment under section
82.34 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

83.1 (ii) if the commissioner determines that a determination of maltreatment for which the
83.2 license holder is responsible is the result of maltreatment that meets the definition of serious
83.3 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit
83.4 \$5,000;

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

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

83.11 For purposes of this section, "occurrence" means each violation identified in the
83.12 commissioner's fine order. Fines assessed against a license holder that holds a license to
83.13 provide home and community-based services, as identified in section 245D.03, subdivision
83.14 1, and a community residential setting or day services facility license under chapter 245D
83.15 where the services are provided, may be assessed against both licenses for the same
83.16 occurrence, but the combined amount of the fines shall not exceed the amount specified in
83.17 this clause for that occurrence.

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

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

83.30 Sec. 6. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended
83.31 to read:

83.32 Subd. 4. **License or certification fee for certain programs.** (a)(1) A program licensed
83.33 to provide one or more of the home and community-based services and supports identified

84.1 under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual
 84.2 nonrefundable license fee based on revenues derived from the provision of services that
 84.3 would require licensure under chapter 245D during the calendar year immediately preceding
 84.4 the year in which the license fee is paid, according to the following schedule:

84.5 License Holder Annual Revenue	License Fee
84.6 less than or equal to \$10,000	\$250
84.7 greater than \$10,000 but less than or 84.8 equal to \$25,000	\$375
84.9 greater than \$25,000 but less than or 84.10 equal to \$50,000	\$500
84.11 greater than \$50,000 but less than or 84.12 equal to \$100,000	\$625
84.13 greater than \$100,000 but less than or 84.14 equal to \$150,000	\$750
84.15 greater than \$150,000 but less than or 84.16 equal to \$200,000	\$1,000
84.17 greater than \$200,000 but less than or 84.18 equal to \$250,000	\$1,250
84.19 greater than \$250,000 but less than or 84.20 equal to \$300,000	\$1,500
84.21 greater than \$300,000 but less than or 84.22 equal to \$350,000	\$1,750
84.23 greater than \$350,000 but less than or 84.24 equal to \$400,000	\$2,000
84.25 greater than \$400,000 but less than or 84.26 equal to \$450,000	\$2,250
84.27 greater than \$450,000 but less than or 84.28 equal to \$500,000	\$2,500
84.29 greater than \$500,000 but less than or 84.30 equal to \$600,000	\$2,850
84.31 greater than \$600,000 but less than or 84.32 equal to \$700,000	\$3,200
84.33 greater than \$700,000 but less than or 84.34 equal to \$800,000	\$3,600
84.35 greater than \$800,000 but less than or 84.36 equal to \$900,000	\$3,900
84.37 greater than \$900,000 but less than or 84.38 equal to \$1,000,000	\$4,250
84.39 greater than \$1,000,000 but less than or 84.40 equal to \$1,250,000	\$4,550
84.41 greater than \$1,250,000 but less than or 84.42 equal to \$1,500,000	\$4,900
84.43 greater than \$1,500,000 but less than or 84.44 equal to \$1,750,000	\$5,200

85.1	greater than \$1,750,000 but less than or	
85.2	equal to \$2,000,000	\$5,500
85.3	greater than \$2,000,000 but less than or	
85.4	equal to \$2,500,000	\$5,900
85.5	greater than \$2,500,000 but less than or	
85.6	equal to \$3,000,000	\$6,200
85.7	greater than \$3,000,000 but less than or	
85.8	equal to \$3,500,000	\$6,500
85.9	greater than \$3,500,000 but less than or	
85.10	equal to \$4,000,000	\$7,200
85.11	greater than \$4,000,000 but less than or	
85.12	equal to \$4,500,000	\$7,800
85.13	greater than \$4,500,000 but less than or	
85.14	equal to \$5,000,000	\$9,000
85.15	greater than \$5,000,000 but less than or	
85.16	equal to \$7,500,000	\$10,000
85.17	greater than \$7,500,000 but less than or	
85.18	equal to \$10,000,000	\$14,000
85.19	greater than \$10,000,000 but less than or	
85.20	equal to \$12,500,000	\$18,000
85.21	greater than \$12,500,000 but less than or	
85.22	equal to \$15,000,000	\$25,000
85.23	greater than \$15,000,000 but less than or	
85.24	equal to \$17,500,000	\$28,000
85.25	greater than \$17,500,000 but less than <u>or</u>	
85.26	<u>equal to</u> \$20,000,000	\$32,000
85.27	greater than \$20,000,000 but less than <u>or</u>	
85.28	<u>equal to</u> \$25,000,000	\$36,000
85.29	greater than \$25,000,000 but less than <u>or</u>	
85.30	<u>equal to</u> \$30,000,000	\$45,000
85.31	greater than \$30,000,000 but less than <u>or</u>	
85.32	<u>equal to</u> \$35,000,000	\$55,000
85.33	greater than \$35,000,000	\$75,000

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

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

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

86.1 (b) A substance use disorder treatment program licensed under chapter 245G, to provide
 86.2 substance use disorder treatment shall pay an annual nonrefundable license fee based on
 86.3 the following schedule:

86.4	Licensed Capacity	License Fee
86.5	1 to 24 persons	\$2,600
86.6	25 to 49 persons	\$3,000
86.7	50 to 74 persons	\$5,000
86.8	75 to 99 persons	\$10,000
86.9	100 to 199 persons	\$15,000
86.10	200 or more persons	\$20,000

86.11 (c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to
 86.12 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay
 86.13 an annual nonrefundable license fee based on the following schedule:

86.14	Licensed Capacity	License Fee
86.15	1 to 24 persons	\$2,600
86.16	25 to 49 persons	\$3,000
86.17	50 or more persons	\$5,000

86.18 A detoxification program that also operates a withdrawal management program at the same
 86.19 location shall only pay one fee based upon the licensed capacity of the program with the
 86.20 higher overall capacity.

86.21 (d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to
 86.22 serve children shall pay an annual nonrefundable license fee based on the following schedule:

86.23	Licensed Capacity	License Fee
86.24	1 to 24 persons	\$1,000
86.25	25 to 49 persons	\$1,100
86.26	50 to 74 persons	\$1,200
86.27	75 to 99 persons	\$1,300
86.28	100 or more persons	\$1,400

86.29 (e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts
 86.30 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual
 86.31 nonrefundable license fee based on the following schedule:

86.32	Licensed Capacity	License Fee
86.33	1 to 24 persons	\$2,600

87.1	25 to 49 persons	\$3,000
87.2	50 or more persons	\$20,000

87.3 (f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
 87.4 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
 87.5 based on the following schedule:

	Licensed Capacity	License Fee
87.6	1 to 24 persons	\$450
87.7	25 to 49 persons	\$650
87.8	50 to 74 persons	\$850
87.9	75 to 99 persons	\$1,050
87.10	100 or more persons	\$1,250

87.12 (g) A program licensed as an adult day care center licensed under Minnesota Rules,
 87.13 parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the
 87.14 following schedule:

	Licensed Capacity	License Fee
87.15	1 to 24 persons	\$2,600
87.16	25 to 49 persons	\$3,000
87.17	50 to 74 persons	\$5,000
87.18	75 to 99 persons	\$10,000
87.19	100 to 199 persons	\$15,000
87.20	200 or more persons	\$20,000

87.22 (h) A program licensed to provide treatment services to persons with sexual psychopathic
 87.23 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
 87.24 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

87.25 (i) A mental health clinic certified under section 245I.20 shall pay an annual
 87.26 nonrefundable certification fee of \$1,550. If the mental health clinic provides services at a
 87.27 primary location with satellite facilities, the satellite facilities shall be certified with the
 87.28 primary location without an additional charge.

87.29 (j) If a program subject to annual fees under paragraph (b) provides services at a primary
 87.30 location with satellite facilities, the satellite facilities must be licensed with the primary
 87.31 location and must be subject to an additional \$500 annual nonrefundable license fee per
 87.32 satellite facility.

88.1 Sec. 7. Minnesota Statutes 2025 Supplement, section 245A.142, subdivision 3, is amended
88.2 to read:

88.3 Subd. 3. **Provisional license.** (a) Beginning January 1, 2026, the commissioner shall
88.4 begin issuing provisional licenses to agencies enrolled under chapter 256B to provide EIDBI
88.5 services.

88.6 (b) Agencies enrolled before July 1, 2025, have until May 31, 2026, to submit an
88.7 application for provisional licensure on the forms and in the manner prescribed by the
88.8 commissioner.

88.9 (c) Beginning June 1, 2026, an agency must not operate if it has not submitted an
88.10 application for provisional licensure under this section. The commissioner shall disenroll
88.11 an agency from providing EIDBI services under chapter 256B if the agency fails to submit
88.12 an application for provisional licensure by May 31, 2026.

88.13 (d) The commissioner must determine whether a provisional license applicant complies
88.14 with all applicable rules and laws and either issue a provisional license to the applicant or
88.15 deny the application by December 31, 2026.

88.16 (e) A provisional license is effective until comprehensive EIDBI agency licensure
88.17 standards are in effect unless the provisional license is suspended or revoked.

88.18 (f) Initial provisional license applications are subject to the \$2,100 application fee under
88.19 section 245A.10, subdivision 3.

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

88.21 Sec. 8. Minnesota Statutes 2025 Supplement, section 245A.242, subdivision 2, is amended
88.22 to read:

88.23 Subd. 2. **Emergency overdose treatment.** (a) A license holder must maintain a supply
88.24 of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency
88.25 treatment of opioid overdose ~~and~~. For administration via intramuscular injection, a license
88.26 holder must have a written standing order protocol by a physician who is licensed under
88.27 chapter 147, advanced practice registered nurse who is licensed under chapter 148, or
88.28 physician assistant who is licensed under chapter 147A, that permits the license holder to
88.29 maintain a supply of intramuscular injection opiate antagonists on site. A license holder
88.30 must require staff to undergo training in the specific mode of administration used at the
88.31 program, which may include intranasal administration, intramuscular injection, or both,
88.32 before the staff has direct contact, as defined in section 245C.02, subdivision 11, with a
88.33 person served by the program.

89.1 (b) Notwithstanding any requirements to the contrary in Minnesota Rules, chapters 2960
89.2 and 9530, and Minnesota Statutes, chapters 245F, 245G, and 245I:

89.3 (1) emergency opiate antagonist medications are not required to be stored in a locked
89.4 area and staff and adult clients may carry this medication on them and store it in an unlocked
89.5 location;

89.6 (2) staff persons who only administer emergency opiate antagonist medications only
89.7 require the training required by paragraph (a), which any knowledgeable trainer may provide.
89.8 The trainer is not required to be a registered nurse or part of an accredited educational
89.9 institution; and

89.10 (3) nonresidential substance use disorder treatment programs that do not administer
89.11 client medications beyond emergency opiate antagonist medications are not required to
89.12 have the policies and procedures required in section 245G.08, subdivisions 5 and 6, and
89.13 must instead describe the program's procedures for administering opiate antagonist
89.14 medications in the license holder's description of health care services under section 245G.08,
89.15 subdivision 1.

89.16 Sec. 9. Minnesota Statutes 2024, section 245C.02, subdivision 18, is amended to read:

89.17 Subd. 18. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse,
89.18 maltreatment resulting in death, neglect resulting in serious injury which reasonably requires
89.19 the care of a physician, advanced practice registered nurse, or physician assistant whether
89.20 or not the care of a physician, advanced practice registered nurse, or physician assistant was
89.21 sought, ~~or~~ abuse resulting in serious injury, or financial exploitation of a vulnerable adult
89.22 if the value of the funds or property is \$1,000 or greater.

89.23 (b) For purposes of this definition, "care of a physician, advanced practice registered
89.24 nurse, or physician assistant" is treatment received or ordered by a physician, physician
89.25 assistant, or advanced practice registered nurse, but does not include:

89.26 (1) diagnostic testing, assessment, or observation;

89.27 (2) the application of, recommendation to use, or prescription solely for a remedy that
89.28 is available over the counter without a prescription; or

89.29 (3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up
89.30 appointment.

89.31 (c) For purposes of this definition, "abuse resulting in serious injury" means: bruises,
89.32 bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries;

90.1 head injuries with loss of consciousness; extensive second-degree or third-degree burns and
90.2 other burns for which complications are present; extensive second-degree or third-degree
90.3 frostbite and other frostbite for which complications are present; irreversible mobility or
90.4 avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are
90.5 harmful; near drowning; and heat exhaustion or sunstroke.

90.6 (d) Serious maltreatment includes neglect when it results in criminal sexual conduct
90.7 against a child or vulnerable adult.

90.8 Sec. 10. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

90.9 Subdivision 1. **Programs licensed by the commissioner.** (a) The commissioner shall
90.10 conduct a background study on:

90.11 (1) the person or persons applying for a license;

90.12 (2) an individual age 13 and over living in the household where the licensed program
90.13 will be provided who is not receiving licensed services from the program;

90.14 (3) current or prospective employees of the applicant or license holder who will have
90.15 direct contact with persons served by the facility, agency, or program;

90.16 (4) volunteers or student volunteers who will have direct contact with persons served
90.17 by the program to provide program services if the contact is not under the continuous, direct
90.18 supervision by an individual listed in clause (1) or (3);

90.19 (5) an individual age ten to 12 living in the household where the licensed services will
90.20 be provided when the commissioner has reasonable cause as defined in section 245C.02,
90.21 subdivision 15;

90.22 (6) an individual who, without providing direct contact services at a licensed program,
90.23 may have unsupervised access to children or vulnerable adults receiving services from a
90.24 program, when the commissioner has reasonable cause as defined in section 245C.02,
90.25 subdivision 15; and

90.26 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

90.27 (8) notwithstanding clause (3), for children's residential facilities and foster residence
90.28 settings, any adult working in the facility, whether or not the individual will have direct
90.29 contact with persons served by the facility.

90.30 (b) For child foster care when the license holder resides in the home where foster care
90.31 services are provided, a short-term substitute caregiver providing direct contact services for

91.1 a child for less than 72 hours of continuous care is not required to receive a background
91.2 study under this chapter.

91.3 (c) This subdivision applies to the following programs that must be licensed under
91.4 chapter 245A:

91.5 (1) adult foster care;

91.6 (2) children's residential facilities;

91.7 (3) licensed home and community-based services under chapter 245D;

91.8 (4) residential mental health programs for adults;

91.9 (5) substance use disorder treatment programs under chapter 245G;

91.10 (6) withdrawal management programs under chapter 245F;

91.11 (7) adult day care centers;

91.12 (8) family adult day services;

91.13 (9) detoxification programs;

91.14 (10) community residential settings;

91.15 (11) intensive residential treatment services and residential crisis stabilization under
91.16 chapter 245I; ~~and~~

91.17 (12) treatment programs for persons with sexual psychopathic personality or sexually
91.18 dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts
91.19 9515.3000 to 9515.3110-; and

91.20 (13) children's foster residence settings.

91.21 **EFFECTIVE DATE.** This section is effective November 3, 2026.

91.22 Sec. 11. Minnesota Statutes 2024, section 245C.04, subdivision 1, is amended to read:

91.23 Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner
91.24 shall conduct a background study of an individual required to be studied under section
91.25 245C.03, subdivision 1, at least upon application for initial license for all license types.

91.26 (b) The commissioner shall conduct a background study of an individual required to be
91.27 studied under section 245C.03, subdivision 1, including a child care background study
91.28 subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed
91.29 child care center, certified license-exempt child care center, or legal nonlicensed child care
91.30 provider, on a schedule determined by the commissioner. Except as provided in section

92.1 245C.05, subdivision 5a, a child care background study must include submission of
92.2 fingerprints for a national criminal history record check and a review of the information
92.3 under section 245C.08. A background study for a child care program must be repeated
92.4 within five years from the most recent study conducted under this paragraph.

92.5 (c) At reauthorization or when a new background study is needed under section 142E.16,
92.6 subdivision 2, for a legal nonlicensed child care provider authorized under chapter 142E:

92.7 (1) for a background study affiliated with a legal nonlicensed child care provider, the
92.8 individual shall provide information required under section 245C.05, subdivision 1,
92.9 paragraphs (a), (b), and (d), to the commissioner and be fingerprinted and photographed
92.10 under section 245C.05, subdivision 5; and

92.11 (2) the commissioner shall verify the information received under clause (1) and submit
92.12 the request in NETStudy 2.0 to complete the background study.

92.13 (d) At reapplication for a family child care license:

92.14 (1) for a background study affiliated with a licensed family child care center, the
92.15 individual shall provide information required under section 245C.05, subdivision 1,
92.16 paragraphs (a), (b), and (d), to the county agency, and be fingerprinted and photographed
92.17 under section 245C.05, subdivision 5;

92.18 (2) the county agency shall verify the information received under clause (1) and forward
92.19 the information to the commissioner and submit the request in NETStudy 2.0 to complete
92.20 the background study; and

92.21 (3) the background study conducted by the commissioner under this paragraph must
92.22 include a review of the information required under section 245C.08.

92.23 ~~(e) The commissioner is not required to conduct a study of an individual at the time of~~
92.24 ~~reapplication for a license if the individual's background study was completed by the~~
92.25 ~~commissioner of human services and the following conditions are met:~~

92.26 ~~(1) a study of the individual was conducted either at the time of initial licensure or when~~
92.27 ~~the individual became affiliated with the license holder;~~

92.28 ~~(2) the individual has been continuously affiliated with the license holder since the last~~
92.29 ~~study was conducted; and~~

92.30 ~~(3) the last study of the individual was conducted on or after October 1, 1995.~~

92.31 ~~(f)~~ (e) The commissioner of human services shall conduct a background study of an
92.32 individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6),

93.1 who is newly affiliated, or currently affiliated without a background study that was submitted
93.2 through the electronic system known as NETStudy 2.0, with a child foster family setting
93.3 license holder:

93.4 (1) the county or private agency shall collect and forward to the commissioner the
93.5 information required under section 245C.05, subdivisions 1 and 5, when the child foster
93.6 family setting applicant or license holder resides in the home where child foster care services
93.7 are provided; and

93.8 (2) the background study conducted by the commissioner of human services under this
93.9 paragraph must include a review of the information required under section 245C.08,
93.10 subdivisions 1, 3, and 4.

93.11 ~~(g)~~ (f) The commissioner shall conduct a background study of an individual specified
93.12 under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly
93.13 affiliated, or currently affiliated without a background study that was submitted through the
93.14 electronic system known as NETStudy 2.0, with an adult foster care or family adult day
93.15 services and with a family child care license holder or a legal nonlicensed child care provider
93.16 authorized under chapter 142E and:

93.17 (1) except as provided in section 245C.05, subdivision 5a, the county shall collect and
93.18 forward to the commissioner the information required under section 245C.05, subdivision
93.19 1, paragraphs (a) and (b), and subdivision 5, paragraph (b), for background studies conducted
93.20 by the commissioner for all family adult day services, for adult foster care when the adult
93.21 foster care license holder resides in the adult foster care residence, and for family child care
93.22 and legal nonlicensed child care authorized under chapter 142E;

93.23 (2) the license holder shall collect and forward to the commissioner the information
93.24 required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs
93.25 (a) and (b), for background studies conducted by the commissioner for adult foster care
93.26 when the license holder does not reside in the adult foster care residence; and

93.27 (3) the background study conducted by the commissioner under this paragraph must
93.28 include a review of the information required under section 245C.08, subdivision 1, paragraph
93.29 (a), and subdivisions 3 and 4.

93.30 ~~(h)~~ (g) Applicants for licensure, license holders, and other entities as provided in this
93.31 chapter must submit completed background study requests to the commissioner using the
93.32 electronic system known as NETStudy 2.0 before individuals specified in section 245C.03,
93.33 subdivision 1, begin positions allowing direct contact in any licensed program.

94.1 ~~(h)~~ (h) For an individual who is not on the entity's active roster, the entity must initiate
 94.2 a new background study through NETStudy when:

94.3 (1) an individual returns to a position requiring a background study following an absence
 94.4 of 120 or more consecutive days; or

94.5 (2) a program that discontinued providing licensed direct contact services for 120 or
 94.6 more consecutive days begins to provide direct contact licensed services again.

94.7 The license holder shall maintain a copy of the notification provided to the commissioner
 94.8 under this paragraph in the program's files. If the individual's disqualification was previously
 94.9 set aside for the license holder's program and the new background study results in no new
 94.10 information that indicates the individual may pose a risk of harm to persons receiving
 94.11 services from the license holder, the previous set-aside shall remain in effect.

94.12 ~~(i)~~ (i) For purposes of this section, a physician licensed under chapter 147, advanced
 94.13 practice registered nurse licensed under chapter 148, or physician assistant licensed under
 94.14 chapter 147A is considered to be continuously affiliated upon the license holder's receipt
 94.15 from the commissioner of health or human services of the physician's, advanced practice
 94.16 registered nurse's, or physician assistant's background study results.

94.17 ~~(j)~~ (j) For purposes of family child care, a substitute caregiver must receive repeat
 94.18 background studies at the time of each license renewal.

94.19 ~~(k)~~ (k) A repeat background study at the time of license renewal is not required if the
 94.20 family child care substitute caregiver's background study was completed by the commissioner
 94.21 on or after October 1, 2017, and the substitute caregiver is on the license holder's active
 94.22 roster in NETStudy 2.0.

94.23 ~~(l)~~ (l) Before and after school programs authorized under chapter 142E, are exempt
 94.24 from the background study requirements under section 123B.03, for an employee for whom
 94.25 a background study under this chapter has been completed.

94.26 Sec. 12. Minnesota Statutes 2025 Supplement, section 245C.07, is amended to read:

94.27 **245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.**

94.28 (a) Subject to the conditions in paragraph (d), when a license holder, applicant, or other
 94.29 entity owns multiple programs or services that are licensed by the Department of Human
 94.30 Services; Department of Children, Youth, and Families; Department of Health; or Department
 94.31 of Corrections, only one background study is required for an individual who provides direct
 94.32 contact services in one or more of the licensed programs or services if:

95.1 (1) the license holder designates one individual with one address and telephone number
95.2 as the person to receive sensitive background study information for the multiple licensed
95.3 programs or services that depend on the same background study; and

95.4 (2) the individual designated to receive the sensitive background study information is
95.5 capable of determining, upon request of the department, whether a background study subject
95.6 is providing direct contact services in one or more of the license holder's programs or services
95.7 and, if so, at which location or locations.

95.8 (b) When a license holder maintains background study compliance for multiple licensed
95.9 programs according to paragraph (a), and one or more of the licensed programs closes, the
95.10 license holder shall immediately notify the commissioner which staff must be transferred
95.11 to an active license so that the background studies can be electronically paired with the
95.12 license holder's active program.

95.13 (c) When a background study is being initiated by a licensed program or service or a
95.14 foster care provider that is also licensed under chapter 144G, a study subject affiliated with
95.15 multiple licensed programs or services may attach to the background study form a cover
95.16 letter indicating the additional names of the programs or services, addresses, and background
95.17 study identification numbers.

95.18 When the commissioner receives a notice, the commissioner shall notify each program
95.19 or service identified by the background study subject of the study results.

95.20 The background study notice the commissioner sends to the subsequent agencies shall
95.21 satisfy those programs' or services' responsibilities for initiating a background study on that
95.22 individual.

95.23 ~~(d) If a background study was conducted on an individual related to child foster care~~
95.24 ~~and the requirements under paragraph (a) are met, the background study is transferable~~
95.25 ~~across all licensed programs.~~ If a background study was conducted on an individual under
95.26 a license other than child foster care and the requirements under paragraph (a) are met, the
95.27 background study is transferable to all licensed programs except child foster care.

95.28 (e) The provisions of this section that allow a single background study in one or more
95.29 licensed programs or services do not apply to background studies submitted by adoption
95.30 agencies, supplemental nursing services agencies, personnel pool agencies, educational
95.31 programs, professional services agencies, temporary personnel agencies, and unlicensed
95.32 personal care provider organizations.

96.1 (f) For an entity operating under NETStudy 2.0, the entity's active roster must be the
96.2 system used to document when a background study subject is affiliated with multiple entities.
96.3 For a background study to be transferable:

96.4 (1) the background study subject must be on and moving to a roster for which the person
96.5 designated to receive sensitive background study information is the same; and

96.6 (2) the same entity must own or legally control both the roster from which the transfer
96.7 is occurring and the roster to which the transfer is occurring. For an entity that holds or
96.8 controls multiple licenses, or unlicensed personal care provider organizations, there must
96.9 be a common highest level entity that has a legally identifiable structure that can be verified
96.10 through records available from the secretary of state.

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

96.12 Sec. 13. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended
96.13 to read:

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

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

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

96.19 (i) the individual is not disqualified; or

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

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

96.30 (3) a notice that a variance has been granted related to the individual under section
96.31 245C.30.

97.1 (b) For a child care background study ~~affiliated with a licensed child care center or~~
97.2 ~~certified license-exempt child care center~~ subject required to submit fingerprints for a
97.3 national criminal history check, except as provided in section 245C.05, subdivision 5a, the
97.4 notice sent under paragraph (a), clause (1), item (ii), must not be issued until the
97.5 commissioner receives a qualifying result for the individual for the fingerprint-based national
97.6 criminal history record check or the fingerprint-based criminal history information from
97.7 the Bureau of Criminal Apprehension. The notice must require the individual to be under
97.8 continuous direct supervision prior to completion of the remainder of the background study
97.9 except as permitted in subdivision 3.

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

97.11 (1) being issued a license;

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

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

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

97.18 (5) for ~~licensed child care centers and certified license-exempt child care centers~~ a child
97.19 care background study subject, providing direct contact services to persons served by the
97.20 program performing any act listed in section 245C.02, subdivision 6a, unless the study is
97.21 being renewed under section 245C.04, subdivision 1, paragraph (b), and it has been less
97.22 than five years since the child care background study subject was previously disqualified
97.23 or provided notice under paragraph (a), clause (1), item (i);

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

97.26 (7) for background studies affiliated with a personal care provider organization, except
97.27 as provided in section 245C.03, subdivision 3b, before a personal care assistant provides
97.28 services, the personal care assistance provider agency must initiate a background study of
97.29 the personal care assistant under this chapter and the personal care assistance provider
97.30 agency must have received a notice from the commissioner that the personal care assistant
97.31 is:

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

98.1 (ii) disqualified, but the personal care assistant has received a set aside of the
98.2 disqualification under section 245C.22; or

98.3 (8) for background studies affiliated with an early intensive developmental and behavioral
98.4 intervention provider, before an individual provides services, the early intensive
98.5 developmental and behavioral intervention provider must initiate a background study for
98.6 the individual under this chapter and the early intensive developmental and behavioral
98.7 intervention provider must have received a notice from the commissioner that the individual
98.8 is:

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

98.10 (ii) disqualified, but the individual has received a set-aside of the disqualification under
98.11 section 245C.22.

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

98.13 Sec. 14. Minnesota Statutes 2024, section 245C.15, subdivision 2, is amended to read:

98.14 Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14
98.15 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any,
98.16 for the offense; and (2) the individual has committed a felony-level violation of any of the
98.17 following offenses: sections 152.021, subdivision 1 or 2b, (aggravated controlled substance
98.18 crime in the first degree; sale crimes); 152.022, subdivision 1 (controlled substance crime
98.19 in the second degree; sale crimes); 152.023, subdivision 1 (controlled substance crime in
98.20 the third degree; sale crimes); 152.024, subdivision 1 (controlled substance crime in the
98.21 fourth degree; sale crimes); 256.98 (wrongfully obtaining assistance); 268.182 (fraud);
98.22 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 518B.01, subdivision 14
98.23 (violation of an order for protection); 609.165 (felon ineligible to possess firearm); 609.2112,
98.24 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.223
98.25 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault
98.26 in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal
98.27 abuse of a vulnerable adult); 609.2334 (violation of an order for protection against financial
98.28 exploitation of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult);
98.29 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.247,
98.30 subdivision 4 (carjacking in the third degree); 609.255 (false imprisonment); 609.2664
98.31 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn
98.32 child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671
98.33 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn
98.34 child in the commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466

99.1 (medical assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b
99.2 (aggravated first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521
99.3 (possession of shoplifting gear); 609.522 (organized retail theft); 609.525 (bringing stolen
99.4 goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535
99.5 (issuance of dishonored checks); 609.542 (illegal remunerations); 609.562 (arson in the
99.6 second degree); 609.563 (arson in the third degree); 609.582 (burglary); 609.59 (possession
99.7 of burglary tools); 609.611 (insurance fraud); 609.625 (aggravated forgery); 609.63 (forgery);
99.8 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false
99.9 pretense); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns);
99.10 609.687 (adulteration); 609.71 (riot); 609.713 (terroristic threats); 609.746 (interference
99.11 with privacy); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud);
99.12 617.23 (indecent exposure), not involving a minor; repeat offenses under 617.241 (obscene
99.13 materials and performances; distribution and exhibition prohibited; penalty); or 624.713
99.14 (certain persons not to possess firearms).

99.15 (b) An individual is disqualified under section 245C.14 if less than 15 years has passed
99.16 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the
99.17 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

99.18 (c) An individual is disqualified under section 245C.14 if less than 15 years has passed
99.19 since the termination of the individual's parental rights under section 260C.301, subdivision
99.20 1, paragraph (b), or subdivision 3.

99.21 (d) An individual is disqualified under section 245C.14 if less than 15 years has passed
99.22 since the discharge of the sentence imposed for an offense in any other state or country, the
99.23 elements of which are substantially similar to the elements of the offenses listed in paragraph
99.24 (a) or since the termination of parental rights in any other state or country, the elements of
99.25 which are substantially similar to the elements listed in paragraph (c).

99.26 (e) If the individual studied commits one of the offenses listed in paragraph (a), but the
99.27 sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is
99.28 disqualified but the disqualification look-back period for the offense is the period applicable
99.29 to the gross misdemeanor or misdemeanor disposition.

99.30 (f) When a disqualification is based on a judicial determination other than a conviction,
99.31 the disqualification period begins from the date of the court order. When a disqualification
99.32 is based on an admission, the disqualification period begins from the date of an admission
99.33 in court. When a disqualification is based on an Alford Plea, the disqualification period
99.34 begins from the date the Alford Plea is entered in court. When a disqualification is based

100.1 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
100.2 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
100.3 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

100.4 Sec. 15. Minnesota Statutes 2024, section 245C.15, subdivision 3, is amended to read:

100.5 Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section
100.6 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed,
100.7 if any, for the offense; and (2) the individual has committed a gross misdemeanor-level
100.8 violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance);
100.9 260B.425 (criminal jurisdiction for contributing to status as a juvenile petty offender or
100.10 delinquency); 260C.425 (criminal jurisdiction for contributing to need for protection or
100.11 services); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud);
100.12 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222
100.13 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth
100.14 degree); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault
100.15 in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243
100.16 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of
100.17 residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal
100.18 neglect of a vulnerable adult); 609.2334 (violation of an order for protection against financial
100.19 exploitation of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult);
100.20 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275
100.21 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in
100.22 prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378
100.23 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft);
100.24 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527
100.25 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks);
100.26 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631
100.27 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72,
100.28 subdivision 3 (disorderly conduct against a vulnerable adult); 609.746 (interference with
100.29 privacy); 609.749, subdivision 2 (harassment); 609.82 (fraud in obtaining credit); 609.821
100.30 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.241
100.31 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293
100.32 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes
100.33 2012, section 609.21; or violation of an order for protection under section 518B.01,
100.34 subdivision 14.

101.1 (b) An individual is disqualified under section 245C.14 if less than ten years has passed
101.2 since the individual's aiding and abetting, attempt, or conspiracy to commit any of the
101.3 offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

101.4 (c) An individual is disqualified under section 245C.14 if less than ten years has passed
101.5 since the discharge of the sentence imposed for an offense in any other state or country, the
101.6 elements of which are substantially similar to the elements of any of the offenses listed in
101.7 paragraph (a).

101.8 (d) If the individual studied commits one of the offenses listed in paragraph (a), but the
101.9 sentence or level of offense is a misdemeanor disposition, the individual is disqualified but
101.10 the disqualification lookback period for the offense is the period applicable to misdemeanors.

101.11 (e) When a disqualification is based on a judicial determination other than a conviction,
101.12 the disqualification period begins from the date of the court order. When a disqualification
101.13 is based on an admission, the disqualification period begins from the date of an admission
101.14 in court. When a disqualification is based on an Alford Plea, the disqualification period
101.15 begins from the date the Alford Plea is entered in court. When a disqualification is based
101.16 on a preponderance of evidence of a disqualifying act, the disqualification date begins from
101.17 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
101.18 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

101.19 Sec. 16. Minnesota Statutes 2024, section 245C.15, subdivision 4, is amended to read:

101.20 Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section
101.21 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed,
101.22 if any, for the offense; and (2) the individual has committed a misdemeanor-level violation
101.23 of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 260B.425
101.24 (criminal jurisdiction for contributing to status as a juvenile petty offender or delinquency);
101.25 260C.425 (criminal jurisdiction for contributing to need for protection or services); 268.182
101.26 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113,
101.27 or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree);
101.28 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231
101.29 (assault in the fourth degree); 609.224 (assault in the fifth degree); 609.2242 (domestic
101.30 assault); 609.2334 (violation of an order for protection against financial exploitation of a
101.31 vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure
101.32 to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the
101.33 third degree); 609.27 (coercion); violation of an order for protection under 609.3232
101.34 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud);

102.1 609.52 (theft); 609.522 (organized retail theft); 609.525 (bringing stolen goods into
102.2 Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance
102.3 of dishonored checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665
102.4 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing telephone
102.5 calls); 609.795 (letter, telegram, or package; opening; harassment); 609.82 (fraud in obtaining
102.6 credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving
102.7 a minor; 617.293 (harmful materials; dissemination and display to minors prohibited); or
102.8 Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section
102.9 518B.01 (Domestic Abuse Act).

102.10 (b) An individual is disqualified under section 245C.14 if less than seven years has
102.11 passed since a determination or disposition of the individual's:

102.12 (1) failure to make required reports under section 260E.06 or 626.557, subdivision 3,
102.13 for incidents in which: (i) the final disposition under section 626.557 or chapter 260E was
102.14 substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

102.15 (2) substantiated serious or recurring maltreatment of a minor under chapter 260E, a
102.16 vulnerable adult under section 626.557, or serious or recurring maltreatment in any other
102.17 state, the elements of which are substantially similar to the elements of maltreatment under
102.18 section 626.557 or chapter 260E for which: (i) there is a preponderance of evidence that
102.19 the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

102.20 (c) An individual is disqualified under section 245C.14 if less than seven years has
102.21 passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of
102.22 the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota
102.23 Statutes.

102.24 (d) An individual is disqualified under section 245C.14 if less than seven years has
102.25 passed since the discharge of the sentence imposed for an offense in any other state or
102.26 country, the elements of which are substantially similar to the elements of any of the offenses
102.27 listed in paragraphs (a) and (b).

102.28 (e) When a disqualification is based on a judicial determination other than a conviction,
102.29 the disqualification period begins from the date of the court order. When a disqualification
102.30 is based on an admission, the disqualification period begins from the date of an admission
102.31 in court. When a disqualification is based on an Alford Plea, the disqualification period
102.32 begins from the date the Alford Plea is entered in court. When a disqualification is based
102.33 on a preponderance of evidence of a disqualifying act, the disqualification date begins from

103.1 the date of the dismissal, the date of discharge of the sentence imposed for a conviction for
103.2 a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

103.3 (f) An individual is disqualified under section 245C.14 if less than seven years has passed
103.4 since the individual was disqualified under section 256.98, subdivision 8.

103.5 Sec. 17. Minnesota Statutes 2025 Supplement, section 245C.15, subdivision 4a, is amended
103.6 to read:

103.7 Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding
103.8 subdivisions 1 to 4, 4b, and 4c, for a background study affiliated with a licensed family
103.9 foster setting, regardless of how much time has passed, an individual is disqualified under
103.10 section 245C.14 if the individual committed an act that resulted in a felony-level conviction
103.11 for sections: 609.185 (murder in the first degree); 609.19 (murder in the second degree);
103.12 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205
103.13 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.221
103.14 (assault in the first degree); 609.223, subdivision 2 (assault in the third degree, past pattern
103.15 of child abuse); 609.223, subdivision 3 (assault in the third degree, victim under four); a
103.16 felony offense under sections 609.2242 and 609.2243 (domestic assault, spousal abuse,
103.17 child abuse or neglect, or a crime against children); 609.2247 (domestic assault by
103.18 strangulation); 609.2325 (criminal abuse of a vulnerable adult resulting in the death of a
103.19 vulnerable adult); 609.245 (aggravated robbery); 609.247, subdivision 2 or 3 (carjacking
103.20 in the first or second degree); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661
103.21 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the
103.22 second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664
103.23 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn
103.24 child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671
103.25 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn
103.26 child in the commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and
103.27 promotion of prostitution; sex trafficking in the first degree); 609.324, subdivision 1 (other
103.28 prohibited acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution);
103.29 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in
103.30 the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal
103.31 sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree);
103.32 609.3453 (criminal sexual predatory conduct); 609.3458 (sexual extortion); 609.352
103.33 (solicitation of children to engage in sexual conduct); 609.377 (malicious punishment of a
103.34 child); 609.3775 (child torture); 609.378 (neglect or endangerment of a child); 609.561
103.35 (arson in the first degree); 609.582, subdivision 1 (burglary in the first degree); 609.746

104.1 (interference with privacy); 617.23 (indecent exposure); 617.246 (use of minors in sexual
104.2 performance prohibited); or 617.247 (possession of child sexual abuse material).

104.3 (b) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for the purposes of a background
104.4 study affiliated with a licensed family foster setting, an individual is disqualified under
104.5 section 245C.14, regardless of how much time has passed, if the individual:

104.6 (1) committed an action under paragraph (e) that resulted in death or involved sexual
104.7 abuse, as defined in section 260E.03, subdivision 20;

104.8 (2) committed an act that resulted in a gross misdemeanor-level conviction for section
104.9 609.3451 (criminal sexual conduct in the fifth degree);

104.10 (3) committed an act against or involving a minor that resulted in a felony-level conviction
104.11 for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the
104.12 third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree);

104.13 or

104.14 (4) committed an act that resulted in a misdemeanor or gross misdemeanor-level
104.15 conviction for section 617.293 (dissemination and display of harmful materials to minors).

104.16 (c) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated
104.17 with a licensed family foster setting, an individual is disqualified under section 245C.14 if
104.18 fewer than 20 years have passed since the termination of the individual's parental rights
104.19 under section 260C.301, subdivision 1, paragraph (b), or if the individual consented to a
104.20 termination of parental rights under section 260C.301, subdivision 1, paragraph (a), to settle
104.21 a petition to involuntarily terminate parental rights. An individual is disqualified under
104.22 section 245C.14 if fewer than 20 years have passed since the termination of the individual's
104.23 parental rights in any other state or country, where the conditions for the individual's
104.24 termination of parental rights are substantially similar to the conditions in section 260C.301,
104.25 subdivision 1, paragraph (b).

104.26 (d) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated
104.27 with a licensed family foster setting, an individual is disqualified under section 245C.14 if
104.28 fewer than five years have passed since a felony-level violation for sections: 152.021
104.29 (controlled substance crime in the first degree); 152.022 (controlled substance crime in the
104.30 second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled
104.31 substance crime in the fourth degree); 152.025 (controlled substance crime in the fifth
104.32 degree); 152.0261 (importing controlled substances across state borders); 152.0262,
104.33 subdivision 1, paragraph (b) (possession of substance with intent to manufacture
104.34 methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic

105.1 cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances);
105.2 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities);
105.3 152.137 (fentanyl- and methamphetamine-related crimes involving children or vulnerable
105.4 adults); 169A.24 (felony first-degree driving while impaired); 243.166 (violation of predatory
105.5 offender registration requirements); 609.2113 (criminal vehicular operation; bodily harm);
105.6 609.2114 (criminal vehicular operation; unborn child); 609.228 (great bodily harm caused
105.7 by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult not resulting in
105.8 the death of a vulnerable adult); 609.233 (criminal neglect); 609.235 (use of drugs to injure
105.9 or facilitate a crime); 609.24 (simple robbery); 609.247, subdivision 4 (carjacking in the
105.10 third degree); 609.322, subdivision 1a (solicitation, inducement, and promotion of
105.11 prostitution; sex trafficking in the second degree); 609.498, subdivision 1 (tampering with
105.12 a witness in the first degree); 609.498, subdivision 1b (aggravated first-degree witness
105.13 tampering); 609.562 (arson in the second degree); 609.563 (arson in the third degree);
105.14 609.582, subdivision 2 (burglary in the second degree); 609.66 (felony dangerous weapons);
105.15 609.687 (adulteration); 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5
105.16 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public
105.17 transit vehicle or facility); or 624.713 (certain people not to possess firearms).

105.18 (e) Notwithstanding subdivisions 1 to 4, 4b, and 4c, except as provided in paragraph
105.19 (a), for a background study affiliated with a licensed family child foster care license, an
105.20 individual is disqualified under section 245C.14 if fewer than five years have passed since:

105.21 (1) a felony-level violation for an act not against or involving a minor that constitutes:
105.22 section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third
105.23 degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the
105.24 fifth degree);

105.25 (2) a violation of an order for protection under section 518B.01, subdivision 14;

105.26 (3) a determination or disposition of the individual's failure to make required reports
105.27 under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition
105.28 under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment
105.29 was recurring or serious;

105.30 (4) a determination or disposition of the individual's substantiated serious or recurring
105.31 maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or
105.32 serious or recurring maltreatment in any other state, the elements of which are substantially
105.33 similar to the elements of maltreatment under chapter 260E or section 626.557 and meet
105.34 the definition of serious maltreatment or recurring maltreatment;

106.1 (5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in
106.2 the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect);
106.3 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child);
106.4 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

106.5 (6) committing an act against or involving a minor that resulted in a misdemeanor-level
106.6 violation of section 609.224, subdivision 1 (assault in the fifth degree).

106.7 (f) For purposes of this subdivision, the disqualification begins from:

106.8 (1) the date of the alleged violation, if the individual was not convicted;

106.9 (2) the date of conviction, if the individual was convicted of the violation but not
106.10 committed to the custody of the commissioner of corrections; or

106.11 (3) the date of release from prison, if the individual was convicted of the violation and
106.12 committed to the custody of the commissioner of corrections.

106.13 Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation
106.14 of the individual's supervised release, the disqualification begins from the date of release
106.15 from the subsequent incarceration.

106.16 (g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the
106.17 offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota
106.18 Statutes, permanently disqualifies the individual under section 245C.14. An individual is
106.19 disqualified under section 245C.14 if fewer than five years have passed since the individual's
106.20 aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs
106.21 (d) and (e).

106.22 (h) An individual's offense in any other state or country, where the elements of the
106.23 offense are substantially similar to any of the offenses listed in paragraphs (a) and (b),
106.24 permanently disqualifies the individual under section 245C.14. An individual is disqualified
106.25 under section 245C.14 if fewer than five years have passed since an offense in any other
106.26 state or country, the elements of which are substantially similar to the elements of any
106.27 offense listed in paragraphs (d) and (e).

106.28 Sec. 18. Minnesota Statutes 2025 Supplement, section 245C.22, subdivision 5, is amended
106.29 to read:

106.30 Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under
106.31 this section, the disqualified individual remains disqualified, but may hold a license and
106.32 have direct contact with or access to persons receiving services. Except as provided in

107.1 paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the
107.2 licensed program, applicant, or agency specified in the set aside notice under section 245C.23.
107.3 For personal care provider organizations, financial management services organizations,
107.4 community first services and supports organizations, unlicensed home and community-based
107.5 organizations, and consumer-directed community supports organizations, the commissioner's
107.6 set-aside may further be limited to a specific individual who is receiving services. For new
107.7 background studies required under section 245C.04, subdivision 1, paragraph ~~(h)~~ (g), if an
107.8 individual's disqualification was previously set aside for the license holder's program and
107.9 the new background study results in no new information that indicates the individual may
107.10 pose a risk of harm to persons receiving services from the license holder, the previous
107.11 set-aside shall remain in effect.

107.12 (b) If the commissioner has previously set aside an individual's disqualification for one
107.13 or more programs or agencies, and the individual is the subject of a subsequent background
107.14 study for a different program or agency, the commissioner shall determine whether the
107.15 disqualification is set aside for the program or agency that initiated the subsequent
107.16 background study. A notice of a set-aside under paragraph (c) shall be issued within 15
107.17 working days if all of the following criteria are met:

107.18 (1) the subsequent background study was initiated in connection with a program licensed
107.19 or regulated under the same provisions of law and rule for at least one program for which
107.20 the individual's disqualification was previously set aside by the commissioner;

107.21 (2) the individual is not disqualified for an offense specified in section 245C.15,
107.22 subdivision 1 or 2;

107.23 (3) the commissioner has received no new information to indicate that the individual
107.24 may pose a risk of harm to any person served by the program; and

107.25 (4) the previous set-aside was not limited to a specific person receiving services.

107.26 (c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the
107.27 substance use disorder field, if the commissioner has previously set aside an individual's
107.28 disqualification for one or more programs or agencies in the substance use disorder treatment
107.29 field, and the individual is the subject of a subsequent background study for a different
107.30 program or agency in the substance use disorder treatment field, the commissioner shall set
107.31 aside the disqualification for the program or agency in the substance use disorder treatment
107.32 field that initiated the subsequent background study when the criteria under paragraph (b),
107.33 clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified

108.1 in section 245C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued
108.2 within 15 working days.

108.3 (d) When a disqualification is set aside under paragraph (b), the notice of background
108.4 study results issued under section 245C.17, in addition to the requirements under section
108.5 245C.17, shall state that the disqualification is set aside for the program or agency that
108.6 initiated the subsequent background study. The notice must inform the individual that the
108.7 individual may request reconsideration of the disqualification under section 245C.21 on the
108.8 basis that the information used to disqualify the individual is incorrect.

108.9 Sec. 19. Minnesota Statutes 2024, section 245C.24, subdivision 2, is amended to read:

108.10 Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in
108.11 paragraphs (b) to ~~(g)~~ (f), the commissioner may not set aside the disqualification of any
108.12 individual disqualified pursuant to this chapter, regardless of how much time has passed,
108.13 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
108.14 1.

108.15 (b) For an individual in the substance use disorder or corrections field who was
108.16 disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose
108.17 disqualification was set aside prior to July 1, 2005, the commissioner must consider granting
108.18 a variance pursuant to section 245C.30 for the license holder for a program dealing primarily
108.19 with adults. A request for reconsideration evaluated under this paragraph must include a
108.20 letter of recommendation from the license holder that was subject to the prior set-aside
108.21 decision addressing the individual's quality of care to children or vulnerable adults and the
108.22 circumstances of the individual's departure from that service.

108.23 (c) If an individual who requires a background study for nonemergency medical
108.24 transportation services under section 245C.03, subdivision 12, was disqualified for a crime
108.25 or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have
108.26 passed since the discharge of the sentence imposed, the commissioner may consider granting
108.27 a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this
108.28 paragraph must include a letter of recommendation from the employer. This paragraph does
108.29 not apply to a person disqualified based on a violation of sections 243.166; 609.185 to
108.30 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3,
108.31 clause (1); 617.246; or 617.247.

108.32 (d) When a licensed foster care provider adopts an individual who had received foster
108.33 care services from the provider for over six months, and the adopted individual is required
108.34 to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause

109.1 (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30
109.2 to permit the adopted individual with a permanent disqualification to remain affiliated with
109.3 the license holder under the conditions of the variance when the variance is recommended
109.4 by the county of responsibility for each of the remaining individuals in placement in the
109.5 home and the licensing agency for the home.

109.6 (e) For an individual 18 years of age or older affiliated with a licensed family foster
109.7 setting, the commissioner must not set aside or grant a variance for the disqualification of
109.8 any individual disqualified pursuant to this chapter, regardless of how much time has passed,
109.9 if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision
109.10 4a, paragraphs (a) and (b).

109.11 (f) In connection with a family foster setting license, the commissioner may grant a
109.12 variance to the disqualification for an individual who is under 18 years of age at the time
109.13 the background study is submitted.

109.14 ~~(g) In connection with foster residence settings and children's residential facilities, the~~
109.15 ~~commissioner must not set aside or grant a variance for the disqualification of any individual~~
109.16 ~~disqualified pursuant to this chapter, regardless of how much time has passed, if the individual~~
109.17 ~~was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraph~~
109.18 ~~(a) or (b).~~

109.19 Sec. 20. Minnesota Statutes 2024, section 245D.04, subdivision 3, is amended to read:

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

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

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

109.26 (3) be free from maltreatment;

109.27 (4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited
109.28 procedure identified in section 245D.06, subdivision 5, or successor provisions, except for:

109.29 (i) emergency use of manual restraint to protect the person from imminent danger to self
109.30 or others according to the requirements in section 245D.061 or successor provisions; or (ii)
109.31 the use of safety interventions as part of a positive support transition plan under section
109.32 245D.06, subdivision 8, or successor provisions;

- 110.1 (5) receive services in a clean and safe environment when the license holder is the owner,
110.2 lessor, or tenant of the service site;
- 110.3 (6) be treated with courtesy and respect and receive respectful treatment of the person's
110.4 property;
- 110.5 (7) reasonable observance of cultural and ethnic practice and religion;
- 110.6 (8) be free from bias and harassment regarding race, gender, age, disability, spirituality,
110.7 and sexual orientation;
- 110.8 (9) be informed of and use the license holder's grievance policy and procedures, including
110.9 knowing how to contact persons responsible for addressing problems and to appeal under
110.10 section 256.045;
- 110.11 (10) know the name, telephone number, and the website, email, and street addresses of
110.12 protection and advocacy services, including the appropriate state-appointed ombudsman,
110.13 and a brief description of how to file a complaint with these offices;
- 110.14 (11) assert these rights personally, or have them asserted by the person's family,
110.15 authorized representative, or legal representative, without retaliation;
- 110.16 (12) give or withhold written informed consent to participate in any research or
110.17 experimental treatment;
- 110.18 (13) associate with other persons of the person's choice in the community;
- 110.19 (14) personal privacy, including the right to use the lock on the person's bedroom or unit
110.20 door;
- 110.21 (15) engage in chosen activities; and
- 110.22 (16) access to the person's personal possessions at any time, including financial resources.
- 110.23 (b) For a person residing in a residential site licensed according to chapter 245A, or
110.24 where the license holder is the owner, lessor, or tenant of the residential service site,
110.25 protection-related rights also include the right to:
- 110.26 (1) have daily, private access to and use of a non-coin-operated telephone for local calls
110.27 and long-distance calls made collect or paid for by the person;
- 110.28 (2) receive and send, without interference, uncensored, unopened mail or electronic
110.29 correspondence or communication;
- 110.30 (3) have use of and free access to common areas in the residence and the freedom to
110.31 come and go from the residence at will;

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

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

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

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

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

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

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

111.13 (c) Restriction of a person's rights under paragraph (a), clauses (13) to (16), or paragraph
111.14 (b), clauses (1) to (7), is allowed only if determined necessary to ensure the health, safety,
111.15 and well-being of the person. Any restriction of those rights must be documented in the
111.16 person's support plan or support plan addendum. The restriction must be implemented in
111.17 the least restrictive alternative manner necessary to protect the person and provide support
111.18 to reduce or eliminate the need for the restriction in the most integrated setting and inclusive
111.19 manner. The documentation must include the following information:

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

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

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

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

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

112.1 Sec. 21. Minnesota Statutes 2024, section 245D.10, subdivision 4, is amended to read:

112.2 Subd. 4. **Availability of current written policies and procedures.** (a) The license
112.3 holder must review and update, as needed, the written policies and procedures required
112.4 under this chapter.

112.5 (b)(1) The license holder must inform the person or the person's legal representative and
112.6 case manager of the policies and procedures affecting a person's rights under section 245D.04,
112.7 and provide copies of those policies and procedures, within five working days of service
112.8 initiation.

112.9 (2) If a license holder only provides basic services and supports, this includes the:

112.10 (i) grievance policy and procedure required under subdivision 2; ~~and~~

112.11 (ii) service suspension and termination policy and procedure required under subdivision
112.12 ~~3;~~ and

112.13 (iii) emergency use of manual restraints policy and procedure required under section
112.14 245D.061, subdivision 9, or successor provisions.

112.15 (3) For all other license holders this includes the:

112.16 (i) policies and procedures in clause (2); and

112.17 ~~(ii) emergency use of manual restraints policy and procedure required under section~~
112.18 ~~245D.061, subdivision 9, or successor provisions; and~~

112.19 ~~(iii)~~ (ii) data privacy requirements under section 245D.11, subdivision 3.

112.20 (c) The license holder must provide a written notice to all persons or their legal
112.21 representatives and case managers at least 30 days before implementing any procedural
112.22 revisions to policies affecting a person's service-related or protection-related rights under
112.23 section 245D.04 and maltreatment reporting policies and procedures. The notice must
112.24 explain the revision that was made and include a copy of the revised policy and procedure.
112.25 The license holder must document the reasonable cause for not providing the notice at least
112.26 30 days before implementing the revisions.

112.27 (d) Before implementing revisions to required policies and procedures, the license holder
112.28 must inform all employees of the revisions and provide training on implementation of the
112.29 revised policies and procedures.

112.30 (e) The license holder must annually notify all persons, or their legal representatives,
112.31 and case managers of any procedural revisions to policies required under this chapter, other
112.32 than those in paragraph (c). Upon request, the license holder must provide the person, or

113.1 the person's legal representative, and case manager with copies of the revised policies and
113.2 procedures.

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

113.4 Sec. 22. Minnesota Statutes 2024, section 256B.02, is amended by adding a subdivision
113.5 to read:

113.6 Subd. 20. **Fraud.** "Fraud" means an intentional deception or misrepresentation made by
113.7 a person with the knowledge that the deception could result in an unauthorized benefit to
113.8 the person or another person or an act, promise to act, or omission made with the intent to
113.9 obtain a benefit in a manner that is prohibited. Fraud includes:

113.10 (1) submitting an application for provider status knowing that the application
113.11 misrepresents, conceals, or fails to disclose any material information;

113.12 (2) intentionally submitting a claim for reimbursement under this chapter, knowing or
113.13 having reason to know the claim is ineligible for reimbursement in whole or in part;

113.14 (3) providing documentation or other information requested by the commissioner having
113.15 knowledge that it is false in any material respect; and

113.16 (4) any act that constitutes the commission, or attempt or conspiracy to commit, a
113.17 violation of any of the following:

113.18 (i) section 256.98 (wrongfully obtaining assistance);

113.19 (ii) section 609.466 (medical assistance fraud);

113.20 (iii) section 609.48 (perjury), involving making a false statement related to medical
113.21 assistance or the receipt of public money;

113.22 (iv) section 609.496 (concealing criminal proceeds) or 609.497 (engaging in business
113.23 of concealing criminal proceeds), involving proceeds consisting of public money;

113.24 (v) section 609.52 (theft), involving theft of property consisting of public money;

113.25 (vi) section 609.542 (illegal remuneration);

113.26 (vii) section 609.625 (aggravated forgery) or 609.63 (forgery), involving falsely filing
113.27 any record, account, or other document with any state agency or department or falsely
113.28 making or altering any record, account, or other document filed with any state agency or
113.29 department;

113.30 (viii) section 609.821 (financial transaction card fraud), involving a public assistance
113.31 benefit;

114.1 (ix) a felony listed in United States Code, title 42, section 1320a-7b(b)(1) or (2), subject
114.2 to any safe harbors established in Code of Federal Regulations, title 42, section 1001.952;
114.3 and

114.4 (x) any other act that constitutes fraud under applicable federal law.

114.5 Sec. 23. Minnesota Statutes 2024, section 256B.04, subdivision 10, is amended to read:

114.6 Subd. 10. **Investigation of certain claims.** The commissioner must establish by rule
114.7 general criteria and procedures for the identification and prompt investigation of suspected
114.8 medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment
114.9 of claims for services not reasonable or medically necessary, or false statement or
114.10 representation of material facts by a vendor of medical care, and for the imposition of
114.11 sanctions against a vendor of medical care. The commissioner may use both prepayment
114.12 and postpayment review systems to review claims submitted by vendors. Payment of claims,
114.13 including payments made after a prepayment review, does not prohibit the commissioner
114.14 from completing a postpayment claims review and taking additional administrative actions
114.15 or monetary recovery against a vendor. If it appears to the state agency that a vendor of
114.16 medical care may have acted in a manner warranting civil or criminal proceedings, it shall
114.17 so inform the attorney general in writing.

114.18 Sec. 24. Minnesota Statutes 2025 Supplement, section 256B.051, subdivision 6, is amended
114.19 to read:

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

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

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

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

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

114.30 (5) provides at the time of enrollment, reenrollment, and revalidation in a format
114.31 determined by the commissioner, proof of surety bond coverage for each business location
114.32 providing services. Upon new enrollment, or if the provider's medical assistance revenue

115.1 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety
115.2 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over
115.3 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
115.4 must be in a form approved by the commissioner, must be ~~renewed~~ purchased new annually,
115.5 and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action
115.6 to obtain monetary recovery or sanctions from a surety bond must occur within six years
115.7 from the date the debt is affirmed by a final agency decision. An agency decision is final
115.8 when the right to appeal the debt has been exhausted or the time to appeal has expired under
115.9 section 256B.064;

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

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

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

115.15 Sec. 25. Minnesota Statutes 2025 Supplement, section 256B.0659, subdivision 21, is
115.16 amended to read:

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

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

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

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

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

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

116.7 (6) a copy of the personal care assistance provider agency's written policies and
116.8 procedures including: hiring of employees; training requirements; service delivery; and
116.9 employee and consumer safety including process for notification and resolution of consumer
116.10 grievances, identification and prevention of communicable diseases, and employee
116.11 misconduct;

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

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

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

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

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

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

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

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

116.31 (12) documentation that the agency will use the following percentages of revenue
116.32 generated from the medical assistance rate paid for personal care assistance services for

117.1 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
117.2 care assistance choice option and 72.5 percent of revenue from other personal care assistance
117.3 providers. The revenue generated by the qualified professional and the reasonable costs
117.4 associated with the qualified professional shall not be used in making this calculation; and

117.5 (13) effective May 15, 2010, documentation that the agency does not burden recipients'
117.6 free exercise of their right to choose service providers by requiring personal care assistants
117.7 to sign an agreement not to work with any particular personal care assistance recipient or
117.8 for another personal care assistance provider agency after leaving the agency and that the
117.9 agency is not taking action on any such agreements or requirements regardless of the date
117.10 signed.

117.11 (b) Personal care assistance provider agencies shall provide the information specified
117.12 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
117.13 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
117.14 the information specified in paragraph (a) from all personal care assistance providers
117.15 beginning July 1, 2009.

117.16 (c) All personal care assistance provider agencies shall require all employees in
117.17 management and supervisory positions and owners of the agency who are active in the
117.18 day-to-day management and operations of the agency to complete mandatory training as
117.19 determined by the commissioner before submitting an application for enrollment of the
117.20 agency as a provider. All personal care assistance provider agencies shall also require
117.21 qualified professionals to complete the training required by subdivision 13 before submitting
117.22 an application for enrollment of the agency as a provider. Employees in management and
117.23 supervisory positions and owners who are active in the day-to-day operations of an agency
117.24 who have completed the required training as an employee with a personal care assistance
117.25 provider agency do not need to repeat the required training if they are hired by another
117.26 agency, if they have completed the training within the past three years. By September 1,
117.27 2010, the required training must be available with meaningful access according to title VI
117.28 of the Civil Rights Act and federal regulations adopted under that law or any guidance from
117.29 the United States Health and Human Services Department. The required training must be
117.30 available online or by electronic remote connection. The required training must provide for
117.31 competency testing. Personal care assistance provider agency billing staff shall complete
117.32 training about personal care assistance program financial management. This training is
117.33 effective July 1, 2009. Any personal care assistance provider agency enrolled before that
117.34 date shall, if it has not already, complete the provider training within 18 months of July 1,
117.35 2009. Any new owners or employees in management and supervisory positions involved

118.1 in the day-to-day operations are required to complete mandatory training as a requisite of
118.2 working for the agency. Personal care assistance provider agencies certified for participation
118.3 in Medicare as home health agencies are exempt from the training required in this
118.4 subdivision. When available, Medicare-certified home health agency owners, supervisors,
118.5 or managers must successfully complete the competency test.

118.6 (d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability
118.7 insurance required by this subdivision must be maintained continuously and purchased new
118.8 annually. After initial enrollment, a provider must submit proof of bonds and required
118.9 coverages at any time at the request of the commissioner. Services provided while there are
118.10 lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions,
118.11 including termination. The commissioner shall send instructions and a due date to submit
118.12 the requested information to the personal care assistance provider agency.

118.13 Sec. 26. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is
118.14 amended to read:

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

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

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

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

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

118.25 (5) provides at the time of enrollment, reenrollment, and revalidation in a format
118.26 determined by the commissioner, proof of surety bond coverage for each business location
118.27 providing services. Upon new enrollment, or if the provider's medical assistance revenue
118.28 in the previous calendar year is \$300,000 or less, the provider agency must purchase a surety
118.29 bond of \$50,000. If the provider's medical assistance revenue in the previous year is over
118.30 \$300,000, the provider agency must purchase a surety bond of \$100,000. The surety bond
118.31 must be in a form approved by the commissioner, must be ~~renewed~~ purchased new annually,
118.32 and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action
118.33 to obtain monetary recovery or sanctions from a surety bond must occur within six years

119.1 from the date the debt is affirmed by a final agency decision. An agency decision is final
119.2 when the right to appeal the debt has been exhausted or the time to appeal has expired under
119.3 section 256B.064;

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

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

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

119.8 Sec. 27. Minnesota Statutes 2024, section 256B.27, subdivision 3, is amended to read:

119.9 Subd. 3. **Access to medical records.** The commissioner of human services, with the
119.10 written consent of the recipient, on file with the local welfare agency, shall be allowed
119.11 access in the manner and within the time prescribed by the commissioner to all personal
119.12 medical records of medical assistance recipients solely for the purposes of investigating
119.13 whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a
119.14 cost report or a rate application which is duplicative, erroneous, or false in whole or in part,
119.15 or which results in the vendor obtaining greater compensation than the vendor is legally
119.16 entitled to; or (b) the medical care was medically necessary. ~~When the commissioner is~~
119.17 ~~investigating a possible overpayment of Medicaid funds,~~ The commissioner may conduct
119.18 on-site inspections of any and all vendors and service locations or may request records from
119.19 a vendor to verify that information submitted to the commissioner is accurate, determine
119.20 compliance with service delivery and billing requirements, and determine compliance with
119.21 any other applicable laws or rules. The commissioner must be given immediate access
119.22 without prior notice to the vendor's office during regular business hours and to documentation
119.23 and records related to services provided and submission of claims for services provided.
119.24 The department shall document in writing the need for immediate access to records related
119.25 to a specific investigation. Denying the commissioner access to records is cause for the
119.26 vendor's immediate suspension of payment or termination according to section 256B.064.
119.27 The determination of provision of services not medically necessary shall be made by the
119.28 commissioner. Notwithstanding any other law to the contrary, a vendor of medical care
119.29 shall not be subject to any civil or criminal liability for providing access to medical records
119.30 to the commissioner of human services pursuant to this section.

120.1 Sec. 28. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 12, is amended
120.2 to read:

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

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

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

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

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

120.21 (5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

121.8 (13) documentation that the agency-provider will use at least the following percentages
121.9 of revenue generated from the medical assistance rate paid for CFSS services for CFSS
121.10 support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except
121.11 100 percent of the revenue generated by a medical assistance rate increase due to a collective
121.12 bargaining agreement under section 179A.54 must be used for support worker wages and
121.13 benefits. The revenue generated by the worker training and development services and the
121.14 reasonable costs associated with the worker training and development services shall not be
121.15 used in making this calculation; and

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

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

121.23 (c) All CFSS agency-providers shall require all employees in management and
121.24 supervisory positions and owners of the agency who are active in the day-to-day management
121.25 and operations of the agency to complete mandatory training as determined by the
121.26 commissioner. Employees in management and supervisory positions and owners who are
121.27 active in the day-to-day operations of an agency who have completed the required training
121.28 as an employee with a CFSS agency-provider do not need to repeat the required training if
121.29 they are hired by another agency and they have completed the training within the past three
121.30 years. CFSS agency-provider billing staff shall complete training about CFSS program
121.31 financial management. Any new owners or employees in management and supervisory
121.32 positions involved in the day-to-day operations are required to complete mandatory training
121.33 as a requisite of working for the agency.

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

122.4 Sec. 29. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 17a, is
122.5 amended to read:

122.6 Subd. 17a. **Consultation services provider qualifications and**
122.7 **requirements.** Consultation services providers must meet the following qualifications and
122.8 requirements:

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

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

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

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

122.16 (5) have proof of surety bond coverage. Upon new enrollment, or if the consultation
122.17 service provider's Medicaid revenue in the previous calendar year is less than or equal to
122.18 \$300,000, the consultation service provider must purchase a surety bond of \$50,000. If the
122.19 agency-provider's Medicaid revenue in the previous calendar year is greater than \$300,000,
122.20 the consultation service provider must purchase a surety bond of \$100,000. The surety bond
122.21 must be in a form approved by the commissioner, must be ~~renewed~~ purchased new annually,
122.22 and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action
122.23 to obtain monetary recovery or sanctions from a surety bond must occur within six years
122.24 from the date the debt is affirmed by a final agency decision. An agency decision is final
122.25 when the right to appeal the debt has been exhausted or the time to appeal has expired under
122.26 section 256B.064;

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

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

122.32 (8) comply with medical assistance provider requirements;

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

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

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

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

123.12 Sec. 30. Minnesota Statutes 2025 Supplement, section 260E.03, subdivision 6, is amended
123.13 to read:

123.14 Subd. 6. **Facility.** "Facility" means:

123.15 (1) a licensed or unlicensed day care facility, certified license-exempt child care center,
123.16 residential facility, agency, psychiatric residential treatment facility, hospital, sanitarium,
123.17 or other facility or institution required to be licensed under sections 144.50 to 144.58,
123.18 241.021, or 245A.01 to 245A.16, or chapter 142B, 142C, 144H, or 245D;

123.19 (2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E;
123.20 or

123.21 (3) a nonlicensed personal care provider organization as defined in section 256B.0625,
123.22 subdivision 19a.

123.23 Sec. 31. Minnesota Statutes 2025 Supplement, section 260E.11, subdivision 1, is amended
123.24 to read:

123.25 Subdivision 1. **Reports of maltreatment in facility.** A person mandated to report child
123.26 maltreatment occurring within a licensed facility shall report the information to the agency
123.27 responsible for licensing or certifying the facility under sections 144.50 to 144.58, 241.021,
123.28 and 245A.01 to 245A.16 or chapter 142B, 142C, 144H, or 245D or to a nonlicensed personal
123.29 care provider organization as defined in section 256B.0625, subdivision 19a. A person
123.30 mandated to report child maltreatment occurring within a federally certified psychiatric
123.31 residential treatment facility must report the information to the Department of Health.

124.1 Sec. 32. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended
124.2 to read:

124.3 Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency
124.4 responsible for investigating allegations of maltreatment in child foster care, family child
124.5 care, legally nonlicensed child care, and reports involving children served by an unlicensed
124.6 personal care provider organization under section 256B.0659. Copies of findings related to
124.7 personal care provider organizations under section 256B.0659 must be forwarded to the
124.8 Department of Human Services provider enrollment.

124.9 (b) The Department of Human Services is the agency responsible for screening and
124.10 investigating allegations of maltreatment in juvenile correctional facilities listed under
124.11 section 241.021 located in the local welfare agency's county and in facilities licensed or
124.12 certified under chapters 245A and 245D, except federally certified psychiatric residential
124.13 treatment facilities.

124.14 (c) The Department of Health is the agency responsible for screening and investigating
124.15 allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43
124.16 to 144A.482 ~~or~~ chapter 144H, or federally certified as a psychiatric residential treatment
124.17 facility.

124.18 (d) The Department of Education is the agency responsible for screening and investigating
124.19 allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11,
124.20 and 13, and chapter 124E. The Department of Education's responsibility to screen and
124.21 investigate includes allegations of maltreatment involving students 18 through 21 years of
124.22 age, including students receiving special education services, up to and including graduation
124.23 and the issuance of a secondary or high school diploma.

124.24 (e) The Department of Human Services is the agency responsible for screening and
124.25 investigating allegations of maltreatment of minors in an EIDBI agency operating under
124.26 sections 245A.142 and 256B.0949.

124.27 (f) A health or corrections agency receiving a report may request the local welfare agency
124.28 to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

124.29 (g) The Department of Children, Youth, and Families is the agency responsible for
124.30 screening and investigating allegations of maltreatment in facilities or programs not listed
124.31 in paragraph (a) that are licensed or certified under chapters 142B and 142C.

125.1 Sec. 33. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended
125.2 to read:

125.3 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
125.4 administrative agency responsible for investigating reports made under section 626.557.

125.5 (a) The Department of Health is the lead investigative agency for facilities or services
125.6 licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding
125.7 care homes, hospice providers, residential facilities that are also federally certified as
125.8 intermediate care facilities that serve people with developmental disabilities, federally
125.9 certified psychiatric residential treatment facilities, or any other facility or service not listed
125.10 in this subdivision that is licensed or required to be licensed by the Department of Health
125.11 for the care of vulnerable adults. "Home care provider" has the meaning provided in section
125.12 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable
125.13 adult's home.

125.14 (b) The Department of Human Services is the lead investigative agency for facilities or
125.15 services licensed or required to be licensed as adult day care, adult foster care, community
125.16 residential settings, programs for people with disabilities, EIDBI agencies, family adult day
125.17 services, mental health programs, mental health clinics, substance use disorder programs,
125.18 the Minnesota Sex Offender Program, or any other facility or service not listed in this
125.19 subdivision that is licensed or required to be licensed by the Department of Human Services,
125.20 except federally certified psychiatric residential treatment facilities. The Department of
125.21 Human Services is also the lead investigative agency for unlicensed EIDBI agencies under
125.22 section 256B.0949.

125.23 (c) The county social service agency or its designee is the lead investigative agency for
125.24 all other reports, including but not limited to reports involving vulnerable adults receiving
125.25 services from a personal care provider organization under section 256B.0659.

125.26 Sec. 34. **NEW BACKGROUND STUDIES FOR INDIVIDUALS NOT IN NETSTUDY**
125.27 **2.0.**

125.28 By March 1, 2027, the commissioner of human services and counties must conduct new
125.29 background studies for all individuals specified under Minnesota Statutes, section 245C.03,
125.30 subdivision 1, paragraph (a), clauses (2) to (6), and affiliated with a child foster family
125.31 setting license holder, adult foster care or family adult day services and with a family child
125.32 care license holder, or a legal nonlicensed child care provider authorized under Minnesota
125.33 Statutes, chapter 142E. The commissioner and counties must follow the requirements in
125.34 Minnesota Statutes, section 245C.04, subdivision 1, paragraphs (e) and (f), when conducting

126.1 the background studies under this section. The new background studies must be submitted
126.2 through NETStudy 2.0.

126.3 **EFFECTIVE DATE.** This section is effective September 1, 2026.

126.4 Sec. 35. **REPEALER.**

126.5 (a) Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3a, is repealed.

126.6 (b) Minnesota Rules, part 9505.2165, subpart 4, is repealed.

126.7 **EFFECTIVE DATE.** Paragraph (a) is effective October 1, 2026.

126.8 **ARTICLE 3**

126.9 **BACKGROUND STUDIES**

126.10 Section 1. Minnesota Statutes 2025 Supplement, section 245C.02, subdivision 15a, is
126.11 amended to read:

126.12 Subd. 15a. **Reasonable cause to require a national criminal history record check.** (a)
126.13 "Reasonable cause to require a national criminal history record check" means information
126.14 or circumstances exist that provide the commissioner with articulable suspicion that further
126.15 pertinent information may exist concerning a background study subject that merits conducting
126.16 a national criminal history record check on that subject. The commissioner has reasonable
126.17 cause to require a national criminal history record check when:

126.18 (1) information from the Bureau of Criminal Apprehension indicates that the subject is
126.19 a multistate offender;

126.20 (2) information from the Bureau of Criminal Apprehension indicates that multistate
126.21 offender status is undetermined;

126.22 (3) the commissioner has received a report from the subject or a third party indicating
126.23 that the subject has a criminal history in a jurisdiction other than Minnesota; or

126.24 (4) information from the Bureau of Criminal Apprehension for a state-based name and
126.25 date of birth background study in which the subject is a minor that indicates that the subject
126.26 has a criminal history.

126.27 (b) In addition to the circumstances described in paragraph (a), the commissioner has
126.28 reasonable cause to require a national criminal history record check if the subject is not
126.29 currently residing in Minnesota or resided in a jurisdiction other than Minnesota during the
126.30 previous five years.

127.1 (c) Reasonable cause to require a national criminal history check does not apply to family
127.2 child foster care ~~or~~, adoption, family adult day services, or adult foster care studies.

127.3 **EFFECTIVE DATE.** This section is effective January 25, 2028.

127.4 Sec. 2. Minnesota Statutes 2024, section 245C.03, subdivision 3a, is amended to read:

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

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

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

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

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

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

127.23 Sec. 3. Minnesota Statutes 2024, section 245C.03, subdivision 9, is amended to read:

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

127.28 (1) owners who have a five percent interest or more, board members, and all managing
127.29 employees are subject to a background study under this chapter. This requirement applies
127.30 to currently enrolled providers and agencies seeking enrollment. "Managing employee" has

128.1 the meaning given in Code of Federal Regulations, title 42, section 455.101. An organization
128.2 is barred from enrollment if:

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

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

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

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

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

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

128.17 **Subd. 17. Providers of adult rehabilitative mental health services.** The commissioner
128.18 shall conduct background studies on any individual who is an owner with an ownership
128.19 stake of at least five percent in an adult rehabilitative mental health services provider, an
128.20 operator of an adult rehabilitative mental health services provider, or an employee or
128.21 volunteer who has direct contact with people receiving adult rehabilitative mental health
128.22 services under section 256B.0623. For the purposes of this subdivision, "operator" includes
128.23 board members or other individuals who oversee the billing, management, or policies of
128.24 the services provided.

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

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

128.29 **Subd. 18. Providers of peer recovery support services.** The commissioner shall conduct
128.30 background studies on any individual who is an owner with an ownership stake of at least
128.31 five percent in a peer recovery support services provider, an operator of a peer recovery
128.32 support services provider, or an employee or volunteer who has direct contact with people

129.1 receiving peer recovery support services under section 254B.052. For the purposes of this
129.2 subdivision, "operator" includes board members or other individuals who oversee the billing,
129.3 management, or policies of the services provided.

129.4 **EFFECTIVE DATE.** This section is effective upon implementation in NETStudy 2.0,
129.5 but no sooner than December 15, 2026.

129.6 Sec. 6. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to
129.7 read:

129.8 **Subd. 19. Providers of adult assertive community treatment services.** The
129.9 commissioner shall conduct background studies on any individual who is an owner with an
129.10 ownership stake of at least five percent in an adult assertive community treatment services
129.11 provider, an operator of an adult assertive community treatment services provider, or an
129.12 employee or volunteer who has direct contact with people receiving adult assertive
129.13 community treatment services under section 256B.0622. For the purposes of this subdivision,
129.14 "operator" includes board members or other individuals who oversee the billing, management,
129.15 or policies of the services provided.

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

129.18 Sec. 7. Minnesota Statutes 2025 Supplement, section 245C.05, subdivision 5, is amended
129.19 to read:

129.20 **Subd. 5. Fingerprints and photograph.** (a) Notwithstanding paragraph (c), for
129.21 background studies conducted by the commissioner for current or prospective child foster
129.22 or adoptive parents, and for any adult working in a children's residential facility, the subject
129.23 of the background study shall provide the commissioner with a set of classifiable fingerprints
129.24 obtained from an authorized agency for a national criminal history record check.

129.25 (b) Notwithstanding paragraph (c), for background studies conducted by the commissioner
129.26 for Head Start programs, the subject of the background study shall provide the commissioner
129.27 with a set of classifiable fingerprints obtained from an authorized agency for a national
129.28 criminal history record check.

129.29 (c) For background studies initiated on or after the implementation of NETStudy 2.0,
129.30 except as provided under subdivision 5a, every subject of a background study must provide
129.31 the commissioner with a set of the background study subject's classifiable fingerprints and
129.32 photograph. The photograph and fingerprints must be recorded at the same time by the

130.1 authorized fingerprint collection vendor or vendors and sent to the commissioner through
130.2 the commissioner's secure data system described in section 245C.32, subdivision 1a,
130.3 paragraph (b).

130.4 (d) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal
130.5 Apprehension and, when specifically required by law, submitted to the Federal Bureau of
130.6 Investigation for a national criminal history record check.

130.7 (e) The fingerprints must not be retained by the Department of Public Safety, Bureau
130.8 of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will
130.9 not retain background study subjects' fingerprints.

130.10 (f) The authorized fingerprint collection vendor or vendors shall, for purposes of verifying
130.11 the identity of the background study subject, be able to view the identifying information
130.12 entered into NETStudy 2.0 by the entity that initiated the background study, but shall not
130.13 retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The
130.14 authorized fingerprint collection vendor or vendors shall retain no more than the name and
130.15 date and time the subject's fingerprints were recorded and sent, only as necessary for auditing
130.16 and billing activities.

130.17 (g) For any background study conducted under this chapter, except for family child
130.18 foster care ~~or~~, adoption, family adult day services, or adult foster care studies, the subject
130.19 shall provide the commissioner with a set of classifiable fingerprints when the commissioner
130.20 has reasonable cause to require a national criminal history record check as defined in section
130.21 245C.02, subdivision 15a.

130.22 **EFFECTIVE DATE.** This section is effective January 25, 2028.

130.23 Sec. 8. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended
130.24 to read:

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

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

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

130.30 (i) the individual is not disqualified; or

130.31 (ii) more time is needed to complete the study but the individual is not required to be
130.32 removed from direct contact or access to people receiving services prior to completion of

131.1 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice
131.2 that more time is needed to complete the study must also indicate whether the individual is
131.3 required to be under continuous direct supervision prior to completion of the background
131.4 study. When more time is necessary to complete a background study of an individual
131.5 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,
131.6 the individual may not work in the facility or setting regardless of whether or not the
131.7 individual is supervised;

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

131.9 (3) a notice that a variance has been granted related to the individual under section
131.10 245C.30.

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

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

131.19 (1) being issued a license;

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

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

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

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

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

131.30 (7) for background studies affiliated with a personal care provider organization, ~~except~~
131.31 ~~as provided in section 245C.03, subdivision 3b,~~ early intensive developmental and behavioral
131.32 intervention provider, housing support or supplementary services provider, special

132.1 transportation services provider, or community first services and supports provider before
 132.2 ~~a personal care assistant~~ an individual provides services, the ~~personal care assistance provider~~
 132.3 ~~agency entity~~ must initiate a background study of the ~~personal care assistant~~ individual
 132.4 under this chapter and the ~~personal care assistance provider agency entity~~ must have received
 132.5 a notice from the commissioner that the ~~personal care assistant~~ individual is:

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

132.7 (ii) disqualified, but the ~~personal care assistant~~ individual has received a set aside of the
 132.8 disqualification under section 245C.22; ~~or.~~

132.9 ~~(8) for background studies affiliated with an early intensive developmental and behavioral~~
 132.10 ~~intervention provider, before an individual provides services, the early intensive~~
 132.11 ~~developmental and behavioral intervention provider must initiate a background study for~~
 132.12 ~~the individual under this chapter and the early intensive developmental and behavioral~~
 132.13 ~~intervention provider must have received a notice from the commissioner that the individual~~
 132.14 ~~is:~~

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

132.16 ~~(ii) disqualified, but the individual has received a set aside of the disqualification under~~
 132.17 ~~section 245C.22.~~

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

132.19

ARTICLE 4

132.20

BEHAVIORAL HEALTH

132.21 Section 1. Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision
 132.22 to read:

132.23 **Subd. 1a. Direct payment.** For purposes of this section, "direct payment" means a
 132.24 funding mechanism used by the commissioner to distribute state appropriations to a county
 132.25 or Tribe for the purpose of carrying out duties, services, or activities authorized under this
 132.26 section. A direct payment is not a grant under section 16B.97 and is not subject to statewide
 132.27 grant-making policies and laws, including but not limited to sections 16A.15 and 16C.05,
 132.28 except as specifically required by the commissioner. A direct payment must be used for the
 132.29 purposes and allowable activities established by the commissioner and is subject to financial
 132.30 oversight, reporting, and monitoring requirements under subdivision 11.

133.1 Sec. 2. Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision
133.2 to read:

133.3 Subd. 3a. **Authority and rulemaking.** (a) The commissioner may distribute money
133.4 under this section through direct payments to counties or Tribes when the commissioner
133.5 determines that a direct payment is the most effective and efficient method to support the
133.6 delivery of adult mental health services, Tribal government activities, or county
133.7 responsibilities under this section. The commissioner shall establish eligibility criteria,
133.8 allowable uses, documentation standards, and reporting requirements for recipients of direct
133.9 payments. The commissioner is authorized to engage in rulemaking to fulfill the requirements
133.10 of this subdivision.

133.11 (b) By January 1, 2027, the commissioner must submit a report to the chairs and ranking
133.12 minority members of the legislative committees with jurisdiction over human services
133.13 finance and policy that includes, at a minimum, the commissioner's plan for determining
133.14 direct payment eligibility criteria, allowable uses of direct payments, documentation
133.15 standards, and reporting requirements for recipients of direct payments.

133.16 Sec. 3. Minnesota Statutes 2025 Supplement, section 245.4661, subdivision 9, is amended
133.17 to read:

133.18 Subd. 9. **Programs and eligible services and programs.** (a) The following three distinct
133.19 grant programs ~~are funded~~ may receive direct payments under this section:

133.20 (1) mental health crisis services;

133.21 (2) housing with supports for adults with serious mental illness; and

133.22 (3) projects for assistance in transitioning from homelessness (PATH program).

133.23 (b) ~~In addition,~~ The following services are eligible for ~~grant funds~~ funding as direct
133.24 payments under this section as the payor of last resort:

133.25 (1) community education and prevention;

133.26 (2) client outreach;

133.27 (3) early identification and intervention;

133.28 (4) adult outpatient diagnostic assessment and psychological testing;

133.29 (5) peer support services;

133.30 (6) community support program services (CSP);

133.31 (7) adult residential crisis stabilization;

- 134.1 (8) supported employment;
- 134.2 (9) assertive community treatment (ACT);
- 134.3 (10) housing subsidies;
- 134.4 (11) basic living, social skills, and community intervention;
- 134.5 (12) emergency response services;
- 134.6 (13) adult outpatient psychotherapy;
- 134.7 (14) adult outpatient medication management;
- 134.8 (15) adult mobile crisis services, including the purchase and renovation of vehicles by
- 134.9 mobile crisis teams in order to provide protected transport under section 256B.0625,
- 134.10 subdivision 17, paragraph (1), clause (6);
- 134.11 (16) adult day treatment;
- 134.12 (17) partial hospitalization;
- 134.13 (18) adult residential treatment;
- 134.14 (19) adult mental health targeted case management; and
- 134.15 (20) transportation.

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

134.17 Sec. 4. Minnesota Statutes 2024, section 245.4661, subdivision 10, is amended to read:

134.18 Subd. 10. **Commissioner duty to report on use of grant funds biennially.** (a) By

134.19 November 1, 2016, and biennially thereafter, the commissioner of ~~human services~~ shall

134.20 provide sufficient information to the members of the legislative committees having

134.21 jurisdiction over mental health funding and policy issues to evaluate the use of funds

134.22 appropriated under this section. The commissioner shall provide, at a minimum, the following

134.23 information:

134.24 (1) the amount of funding to adult mental health initiatives, what programs and services

134.25 were funded in the previous two years, gaps in services that each initiative brought to the

134.26 attention of the commissioner, and outcome data for the programs and services that were

134.27 funded; and

134.28 (2) the amount of funding for other targeted services and the location of services.

134.29 (b) This subdivision expires January 1, 2032.

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

135.2 Sec. 5. Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision
135.3 to read:

135.4 Subd. 12. **Oversight of direct payments.** (a) The commissioner shall develop and
135.5 maintain monitoring, financial review, and accountability procedures for all direct payments
135.6 issued under this section.

135.7 (b) Recipients of direct payments must comply with all documentation, reporting, and
135.8 expenditure requirements established by the commissioner.

135.9 (c) The commissioner may require corrective action, suspend payments, or recover
135.10 money if a recipient fails to comply with requirements established under this subdivision.

135.11 (d) The commissioner shall develop a direct payment acknowledgment process to ensure
135.12 that recipients understand the terms, conditions, and oversight requirements associated with
135.13 direct payments.

135.14 (e) The commissioner is authorized to engage in rulemaking to fulfill the requirements
135.15 of this subdivision.

135.16 (f) By January 1, 2027, the commissioner must submit a report to the chairs and ranking
135.17 minority members of the legislative committees with jurisdiction over human services
135.18 finance and policy that, at a minimum, describes the commissioner's development of the
135.19 monitoring, financial review, and accountability procedures as required under this section.

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

135.21 Sec. 6. Minnesota Statutes 2024, section 254A.03, subdivision 2, is amended to read:

135.22 Subd. 2. **American Indian programs.** There is hereby created a section of American
135.23 Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human
135.24 Services, to be headed by a special assistant for American Indian programs on substance
135.25 misuse and substance use disorder and two assistants to that position. The section shall be
135.26 staffed with all personnel necessary to fully administer programming for substance misuse
135.27 and substance use disorder services for American Indians in the state. The special assistant
135.28 position shall be filled by a person with considerable practical experience in and
135.29 understanding of substance misuse and substance use disorder in the American Indian
135.30 community, who shall be responsible to the director of the Alcohol and Drug Abuse Section
135.31 created in subdivision 1 and shall be in the unclassified service. The special assistant shall
135.32 meet and consult with the American Indian Advisory Council as described in section

136.1 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report
136.2 on the status of substance misuse and substance use disorder among American Indians in
136.3 the state of Minnesota. The special assistant with the approval of the director shall:

136.4 (1) administer direct payments using funds appropriated for American Indian groups,
136.5 organizations and reservations within the state for American Indian substance misuse and
136.6 substance use disorder programs;

136.7 (2) establish policies and procedures for such American Indian programs with the
136.8 assistance of the American Indian Advisory Board; and

136.9 (3) hire and supervise staff to assist in the administration of the American Indian program
136.10 section within the Alcohol and Drug Abuse Section of the Department of Human Services.

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

136.12 Sec. 7. Minnesota Statutes 2025 Supplement, section 254B.02, subdivision 5, is amended
136.13 to read:

136.14 Subd. 5. **Tribal allocation.** The commissioner may make direct payments to Tribal
136.15 Nation servicing agencies from money allocated under this section to support individuals
136.16 with substance use disorders and determine eligibility for behavioral health fund payments.
136.17 The payment must not be less than 133 percent of the Tribal Nations payment for the fiscal
136.18 year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation
136.19 for this chapter.

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

136.21 Sec. 8. Minnesota Statutes 2025 Supplement, section 254B.0503, subdivision 1, is amended
136.22 to read:

136.23 Subdivision 1. **Eligible vendor requirements.** (a) Vendors of room and board are
136.24 eligible for behavioral health fund payment if the vendor:

136.25 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals
136.26 while residing in the facility and provide consequences for infractions of those rules;

136.27 (2) is determined to meet applicable health and safety requirements;

136.28 (3) is not a jail or prison;

136.29 (4) is not concurrently receiving funds under chapter 256I for the recipient;

136.30 (5) admits individuals who are 18 years of age or older;

137.1 (6) is registered as a board and lodging or lodging establishment according to section
137.2 157.17;

137.3 (7) has awake staff on site whenever a client is present;

137.4 (8) has staff who are at least 18 years of age and meet the requirements of section
137.5 245G.11, subdivision 1, paragraph (b);

137.6 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;

137.7 (10) meets the requirements of section 245G.08, subdivision 5, if administering
137.8 medications to clients;

137.9 (11) meets the abuse prevention requirements of section 245A.65, including a policy on
137.10 fraternization and the mandatory reporting requirements of section 626.557;

137.11 (12) documents coordination with the treatment provider to ensure compliance with
137.12 section 254B.03, subdivision 2;

137.13 (13) protects client funds and ensures freedom from exploitation by meeting the
137.14 provisions of section 245A.04, subdivision 13;

137.15 (14) has a grievance procedure that meets the requirements of section 245G.15,
137.16 subdivision 2; and

137.17 (15) has sleeping and bathroom facilities for men and women separated by a door that
137.18 is locked, has an alarm, or is supervised by awake staff.

137.19 (b) Programs providing children's mental health crisis admissions and stabilization under
137.20 section 245.4882, subdivision 6, are eligible vendors of room and board.

137.21 (c) Programs providing children's residential services under section 245.4882, except
137.22 services for individuals who have a placement under chapter 260C or 260D, are eligible
137.23 vendors of room and board.

137.24 (d) A vendor that is not licensed as a residential treatment program must have a policy
137.25 to address staffing coverage when a client may unexpectedly need to be present at the room
137.26 and board site.

137.27 (e) No new vendors for room and board services may be approved after June 30, 2025,
137.28 to receive payments from the behavioral health fund, under the provisions of section 254B.04,
137.29 subdivision 2a. Room and board vendors that were approved and operating prior to July 1,
137.30 2025, may continue to receive payments from the behavioral health fund for services provided
137.31 until ~~June 30, 2027~~ December 31, 2026. Room and board vendors providing services in

138.1 accordance with section 254B.04, subdivision 2a, will no longer be eligible to claim
138.2 reimbursement for room and board services provided on or after ~~July~~ January 1, 2027.

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

138.4 Sec. 9. Minnesota Statutes 2025 Supplement, section 254B.0505, subdivision 8, is amended
138.5 to read:

138.6 Subd. 8. **Peer recovery support services requirements.** Eligible vendors of peer
138.7 recovery support services must:

138.8 ~~(1)~~ submit to a review by the commissioner of up to ten percent of all medical assistance
138.9 and behavioral health fund claims to determine the medical necessity of peer recovery
138.10 support services for entities billing for peer recovery support services individually and not
138.11 receiving a daily rate; ~~and,~~

138.12 ~~(2) limit an individual client to 14 hours per week for peer recovery support services~~
138.13 ~~from an individual provider of peer recovery support services.~~

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

138.15 Sec. 10. Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding
138.16 a subdivision to read:

138.17 Subd. 9. **Billing limits.** (a) Treatment coordination must not exceed five hours per week
138.18 per recipient.

138.19 (b) Peer recovery support services must not exceed ten hours per week per recipient.
138.20 Services must be provided in person and must not include time spent transporting a recipient.

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

138.22 Sec. 11. Minnesota Statutes 2025 Supplement, section 254B.0509, subdivision 2, is
138.23 amended to read:

138.24 Subd. 2. **Annual adjustments.** Effective January 1, 2027, and annually thereafter, the
138.25 commissioner of human services must adjust the payment rates under ~~subdivision 1~~ section
138.26 254B.0505, subdivision 1, clauses (1) to (9), according to the change from the midpoint of
138.27 the previous rate year to the midpoint of the rate year for which the rate is being determined
138.28 using the Centers for Medicare and Medicaid Services Medicare Economic Index as
138.29 forecasted in the fourth quarter of the calendar year before the rate year. Notwithstanding
138.30 this subdivision, rates must not be adjusted lower than those established on January 1, 2026.

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

139.2 Sec. 12. Minnesota Statutes 2024, section 254B.17, is amended to read:

139.3 **254B.17 WITHDRAWAL MANAGEMENT START-UP AND**
 139.4 **CAPACITY-BUILDING GRANTS.**

139.5 The commissioner must establish start-up and capacity-building grants for prospective
 139.6 ~~or~~, new, or existing substance use disorder treatment or withdrawal management programs
 139.7 ~~licensed under chapter 245F~~ that will meet ASAM criteria for medically ~~monitored~~ managed
 139.8 or clinically monitored levels of care by integrating withdrawal management services into
 139.9 outpatient, intensive outpatient, or residential treatment services. Grants must be used to
 139.10 measurably increase client capacity or expand available services and must align services
 139.11 with ASAM criteria. Grants may be used to add medications for opioid use disorder to a
 139.12 grantee's available services and for capacity-building expenses that are not reimbursable
 139.13 under Minnesota health care programs, including but not limited to:

139.14 (1) costs associated with hiring staff or contracting with medical services providers;

139.15 (2) costs associated with staff retention;

139.16 (3) the purchase of office equipment and supplies;

139.17 (4) the purchase of software;

139.18 (5) costs associated with obtaining applicable and required licenses;

139.19 (6) business formation costs;

139.20 (7) costs associated with staff training; ~~and~~

139.21 (8) the purchase of medical equipment and supplies necessary to meet health and safety
 139.22 requirements;

139.23 (9) costs associated with adding or improving physical space;

139.24 (10) start-up costs associated with adding new locations; and

139.25 (11) costs associated with becoming ASAM certified for medically managed levels of
 139.26 care.

139.27 Sec. 13. Minnesota Statutes 2024, section 256B.04, subdivision 23, is amended to read:

139.28 Subd. 23. **Medical assistance costs for certain inmates.** (a) The commissioner shall
 139.29 execute an interagency agreement with the commissioner of corrections to recover the state
 139.30 cost attributable to medical assistance eligibility for inmates of public institutions admitted

140.1 to a medical institution on an inpatient basis. The annual amount to be transferred from the
140.2 Department of Corrections under the agreement must include all eligible state medical
140.3 assistance costs, including administrative costs incurred by the Department of Human
140.4 Services, attributable to inmates under state and county jurisdiction admitted to medical
140.5 institutions on an inpatient basis that are related to the implementation of section 256B.055,
140.6 subdivision 14, paragraph (c). This paragraph expires upon the effective date of paragraph
140.7 (b).

140.8 (b) Effective January 1, 2027, or upon federal approval, whichever is later, the
140.9 commissioner shall execute an interagency agreement with the commissioner of corrections
140.10 to recover the state cost attributable to medical assistance eligibility for inmates of public
140.11 institutions admitted to a medical institution on an inpatient basis. The annual amount to
140.12 be transferred from the Department of Corrections under the agreement must include all
140.13 eligible state medical assistance costs, including administrative costs incurred by the
140.14 Department of Human Services attributable to inmates under state and county jurisdiction
140.15 admitted to medical institutions on an inpatient basis that are related to implementation of
140.16 section 256B.0618, paragraph (b).

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

140.18 **Sec. 14. [256B.0618] COVERAGE FOR DETAINED INDIVIDUALS.**

140.19 (a) An inmate of a correctional facility who is conditionally released under section
140.20 241.26, 244.065, or 631.425 is eligible for medical assistance if the individual:

140.21 (1) does not require the security of a public detention facility and is housed:

140.22 (i) in a halfway house or community correction center; or

140.23 (ii) under house arrest and monitored by electronic surveillance in a residence approved
140.24 by the commissioner of corrections; and

140.25 (2) meets all other eligibility requirements of this chapter.

140.26 (b) An individual, regardless of age, who is considered an inmate of a public institution
140.27 as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the
140.28 eligibility requirements in section 256B.056 is not eligible for medical assistance, except
140.29 for covered medical assistance services received:

140.30 (1) while an inpatient in a medical institution as defined in Code of Federal Regulations,
140.31 title 42, section 435.1010;

141.1 (2) by an eligible juvenile in accordance with the Consolidated Appropriations Act,
141.2 2023, Public Law 117-328, part 5121; and

141.3 (3) by an eligible individual under with section 256B.0761.

141.4 (c) Security logistics and costs related to the inpatient treatment of an inmate are the
141.5 responsibility of the entity that has jurisdiction over the inmate.

141.6 **EFFECTIVE DATE.** This section is effective January 1, 2028.

141.7 Sec. 15. **[256B.0619] CARCERAL TARGETED CASE MANAGEMENT SERVICES.**

141.8 Subdivision 1. **Generally.** Effective January 1, 2028, or upon federal approval, whichever
141.9 is later, medical assistance covers carceral targeted case management services in accordance
141.10 with section 256B.0761 and United States Code, title 42, sections 1396a(a)(84); 1396d(a)(32);
141.11 1397bb(d); and 1397jj(b)(2) and (7).

141.12 Subd. 2. **Definitions.** (a) For purposes of this section, the following terms have the
141.13 meanings given.

141.14 (b) "Comprehensive care plan" means a person-centered plan that includes goals, tasks,
141.15 and services identified through screening and assessments and agreed upon by all parties.
141.16 A comprehensive care plan includes but is not limited to identifying resources and services
141.17 necessary to meet the individual's physical, behavioral health, and health-related social
141.18 needs prerelease and postrelease.

141.19 (c) "Consultation" means communication from a carceral targeted case manager to other
141.20 providers working with the same justice-involved individual to (1) inform, inquire, and
141.21 instruct providers on the individual's symptoms, strategies for effective engagement, care
141.22 and intervention needs, and treatment expectations across service settings, and (2) direct
141.23 and coordinate clinical service components provided to the justice-involved individual.
141.24 Service settings and components include but are not limited to education services, social
141.25 services, probation, an individual's home, primary care, medication prescribers, disabilities
141.26 services, and services from other mental health providers.

141.27 (d) "Targeted case management for justice-involved individuals" means the provision
141.28 of both county targeted case management and public or private vendor service coordination
141.29 services to bridge prerelease and postrelease medical assistance services that support the
141.30 physical, behavioral, and health-related social needs of justice-involved individuals.

141.31 (e) "Targeted case management services" means services that assist medical assistance
141.32 eligible persons with accessing needed medical, social, educational, and other services.

142.1 Subd. 3. Eligibility. The following individuals are eligible for carceral targeted case
142.2 management services:

142.3 (1) individuals eligible for medical assistance who meet all eligibility requirements under
142.4 United States Code, title 42, section 1396a(nn), through direct coordination between providers
142.5 that includes timely communication, active engagement of the individual when feasible,
142.6 and facilitation of continuity of care upon release;

142.7 (2) individuals eligible for medical assistance who meet eligibility requirements for the
142.8 Children's Health Insurance Program under United States Code, title 42, section 1397jj(b)(7);
142.9 or

142.10 (3) individuals eligible for medical assistance who are currently incarcerated at a section
142.11 1115 reentry demonstration pilot facility and meet the participation requirements in section
142.12 256B.0761, subdivision 2.

142.13 Subd. 4. Carceral targeted case management services. (a) For individuals eligible for
142.14 services under subdivision 3, clause (1) or (2), carceral targeted case management care
142.15 coordination is available for 30 days before release and up to 180 days postrelease. For
142.16 individuals eligible for services under subdivision 3, clause (3), carceral targeted case
142.17 management care coordination is available for up to 90 days before release and up to 180
142.18 days postrelease.

142.19 (b) Carceral targeted case management care coordination includes:

142.20 (1) comprehensive assessment and periodic reassessment addressing physical, behavioral,
142.21 and health-related social needs in accordance with section 256B.0761 and United States
142.22 Code, title 42, sections 1396a(nn) and 1397jj(b)(7);

142.23 (2) comprehensive care plans, including but not limited to:

142.24 (i) the desired goals of the individual;

142.25 (ii) the individual's preferences for services and supports;

142.26 (iii) formal and informal services and supports based on areas of assessment, such as
142.27 social health, mental health, residence, family, education and vocation, safety, legal,
142.28 self-determination, financial, and chemical health; and

142.29 (iv) housing arrangements postrelease;

142.30 (3) regular review and revision of the comprehensive care plan with the individual to
142.31 ensure needs are adequately met by referrals and supports;

143.1 (4) coordination of referrals, which must consist of efforts beyond providing a list of
143.2 resources, to bridge prerelease to postrelease medical assistance services, including but not
143.3 limited to referrals to community-based services identified as a need on the comprehensive
143.4 care plan;

143.5 (5) warm handoffs and follow-up post release;

143.6 (6) monitoring and evaluation of services identified in the comprehensive care plan to
143.7 ensure personal outcomes are met and to ensure satisfaction with services and service
143.8 delivery;

143.9 (7) consultation with other professionals, including but not limited to community-based
143.10 mental health providers; and

143.11 (8) completion and maintenance of necessary documentation that supports and verifies
143.12 the activities in this section.

143.13 **Subd. 5. Carceral targeted case management provider standards.** Providers eligible
143.14 to receive medical assistance reimbursement under this section must enroll as a Minnesota
143.15 health care programs provider. To qualify as a provider of carceral targeted case management
143.16 services, a provider must:

143.17 (1) have a minimum of a bachelor's degree or a license in a health or human services
143.18 field, comparable training and two years of experience in human services, or credentials
143.19 from an American Indian Tribe under section 256B.02, subdivision 7;

143.20 (2) demonstrate the capacity and experience to provide targeted case management
143.21 activities for justice-involved individuals as defined in subdivision 2;

143.22 (3) be able to coordinate and connect community resources needed by the recipient;

143.23 (4) demonstrate administrative capacity and experience to serve the justice-involved
143.24 population for which the provider will provide services and to ensure quality of services
143.25 under state and federal requirements;

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

143.28 (6) demonstrate capacity to document and maintain individual case records under state
143.29 and federal requirements;

143.30 (7) demonstrate the capacity to coordinate with county administrative functions;

143.31 (8) be able to coordinate with health care providers to ensure access to necessary health
143.32 care services;

144.1 (9) have a procedure that:

144.2 (i) notifies the recipient of any conflict of interest if the targeted case management service
144.3 provider also provides the recipient's services and supports;

144.4 (ii) provides information on all potential conflicts of interest;

144.5 (iii) obtains the recipient's informed consent; and

144.6 (iv) provides the recipient with alternatives; and

144.7 (10) demonstrate the capacity to achieve the following performance outcomes: (i) access;
144.8 (ii) quality; and (iii) consumer satisfaction.

144.9 Subd. 6. **Medical assistance payment and rate setting.** (a) Carceral targeted case
144.10 management rates are equal to rates authorized by the commissioner for relocation targeted
144.11 case management under section 256B.0621, subdivision 10.

144.12 (b) The carceral targeted case management rate only includes eligible services delivered
144.13 to an eligible recipient by an eligible provider.

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

144.15 Sec. 16. Minnesota Statutes 2024, section 256B.0623, is amended by adding a subdivision
144.16 to read:

144.17 Subd. 15. **Billing limits.** Effective January 1, 2027, services under this section must not
144.18 exceed four hours per week per recipient, with a maximum of 18 hours per month. Prior
144.19 authorization is required for services exceeding 200 hours per year.

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

144.22 Subd. 77. **Carceral targeted case management.** Effective January 1, 2028, or upon
144.23 federal approval, whichever is later, medical assistance covers carceral targeted case
144.24 management services under section 256B.0619.

144.25 Sec. 18. Minnesota Statutes 2024, section 256B.0671, is amended by adding a subdivision
144.26 to read:

144.27 Subd. 14. **Billing limits.** Child and family psychoeducation services under this section
144.28 must not exceed two hours per day, three days per week per recipient.

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

145.1 Sec. 19. Minnesota Statutes 2024, section 256B.0761, subdivision 2, is amended to read:

145.2 Subd. 2. **Eligible individuals.** (a) Notwithstanding section 256B.055, subdivision 14,
145.3 individuals are eligible to receive services under this demonstration if they are eligible under
145.4 section 256B.055, subdivision 3a, 6, 7, 7a, 9, 15, 16, or 17, as determined by the
145.5 commissioner in collaboration with correctional facilities, local governments, and Tribal
145.6 governments. This paragraph expires upon the effective date of paragraph (b).

145.7 (b) Effective January 1, 2027, or upon federal approval, whichever is later, individuals
145.8 are eligible to receive services under this demonstration if they are eligible under section
145.9 256B.055, subdivision 3a, 6, 7, 7a, 9, 15, 16, or 17, as determined by the commissioner in
145.10 collaboration with correctional facilities, local governments, and Tribal governments.

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

145.12 Sec. 20. Minnesota Statutes 2024, section 256B.0761, subdivision 3, is amended to read:

145.13 Subd. 3. **Eligible correctional facilities.** (a) The commissioner's waiver application is
145.14 limited to:

145.15 (1) three state correctional facilities to be determined by the commissioner of corrections,
145.16 one of which must be the Minnesota Correctional Facility-Shakopee;

145.17 ~~(2) two facilities for delinquent children and youth licensed under section 241.021,~~
145.18 ~~subdivision 2, identified in coordination with the Minnesota Juvenile Detention Association~~
145.19 ~~and the Minnesota Sheriffs' Association;~~

145.20 ~~(3)~~ (2) four correctional facilities for adults licensed under section 241.021, subdivision
145.21 1, identified in coordination with the Minnesota Sheriffs' Association and the Association
145.22 of Minnesota Counties; and

145.23 ~~(4)~~ (3) one correctional facility owned and managed by a Tribal government or a facility
145.24 located outside of the seven-county metropolitan area that has an inmate census with a
145.25 significant proportion of Tribal members or American Indians.

145.26 (b) Additional facilities may be added to the waiver contingent on legislative authorization
145.27 and appropriations.

146.1 Sec. 21. Minnesota Statutes 2024, section 256B.0943, is amended by adding a subdivision
146.2 to read:

146.3 Subd. 14. **Billing limits.** (a) Skills training under this section must not exceed two hours
146.4 per day, three days per week per recipient. Prior authorization is required for services
146.5 exceeding 200 hours per year.

146.6 (b) Mental health behavioral aide services under this section must not exceed six hours
146.7 per day, three days per week per recipient. Prior authorization is required for services
146.8 exceeding 200 hours per year.

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

146.10 Sec. 22. Minnesota Statutes 2025 Supplement, section 256I.04, subdivision 2a, is amended
146.11 to read:

146.12 Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph
146.13 (b), an agency may not enter into an agreement with an establishment to provide housing
146.14 support unless:

146.15 (1) the establishment is licensed by the Department of Health as a hotel and restaurant;
146.16 a board and lodging establishment; a boarding care home before March 1, 1985; or a
146.17 supervised living facility, and the service provider for residents of the facility is licensed
146.18 under chapter 245A. However, an establishment licensed by the Department of Health to
146.19 provide lodging need not also be licensed to provide board if meals are being supplied to
146.20 residents under a contract with a food vendor who is licensed by the Department of Health;

146.21 (2) the residence is: (i) licensed by the commissioner of human services under Minnesota
146.22 Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior
146.23 to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265;
146.24 (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120,
146.25 with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02,
146.26 subdivision 4a, as a community residential setting by the commissioner of human services;

146.27 (3) the facility is licensed under chapter 144G and provides three meals a day; or

146.28 (4) effective ~~January 1, 2027~~ July 1, 2026, the establishment is licensed by the Department
146.29 of Health as a board and lodging establishment and is certified by the commissioner as a
146.30 recovery residence in accordance with section 254B.215, subdivision 3, that is subject to
146.31 the requirements of section 256I.04, subdivisions 2a to 2f. The Department of Human
146.32 Services must serve as the lead agency for agreements entered into under this clause.

147.1 (b) The requirements under paragraph (a) do not apply to establishments exempt from
147.2 state licensure because they are:

147.3 (1) located on Indian reservations and subject to tribal health and safety requirements;

147.4 or

147.5 (2) supportive housing establishments where an individual has an approved habitability
147.6 inspection and an individual lease agreement.

147.7 (c) Supportive housing establishments that serve individuals who have experienced
147.8 long-term homelessness and emergency shelters must participate in the homeless management
147.9 information system and a coordinated assessment system as defined by the commissioner.

147.10 (d) Effective July 1, 2016, an agency shall not have an agreement with a provider of
147.11 housing support unless all staff members who have direct contact with recipients:

147.12 (1) have skills and knowledge acquired through one or more of the following:

147.13 (i) a course of study in a health- or human services-related field leading to a bachelor
147.14 of arts, bachelor of science, or associate's degree;

147.15 (ii) one year of experience with the target population served;

147.16 (iii) experience as a mental health certified peer specialist according to section 256B.0615;

147.17 or

147.18 (iv) meeting the requirements for unlicensed personnel under sections 144A.43 to
147.19 144A.483;

147.20 (2) hold a current driver's license appropriate to the vehicle driven if transporting
147.21 recipients;

147.22 (3) complete training on vulnerable adults mandated reporting and child maltreatment
147.23 mandated reporting, where applicable; and

147.24 (4) complete housing support orientation training offered by the commissioner.

147.25 Sec. 23. Minnesota Statutes 2024, section 297E.02, subdivision 3, is amended to read:

147.26 Subd. 3. **Collection; disposition.** (a) Taxes imposed by this section are due and payable
147.27 to the commissioner when the gambling tax return is required to be filed. Distributors must
147.28 file their monthly sales figures with the commissioner on a form prescribed by the
147.29 commissioner. Returns covering the taxes imposed under this section must be filed with
147.30 the commissioner on or before the 20th day of the month following the close of the previous
147.31 calendar month. The commissioner shall prescribe the content, format, and manner of returns

148.1 or other documents pursuant to section 270C.30. The proceeds, along with the revenue
148.2 received from all license fees and other fees under sections 349.11 to 349.191, 349.211,
148.3 and 349.213, must be paid to the commissioner of management and budget for deposit in
148.4 the general fund.

148.5 (b) The sales tax imposed by chapter 297A on the sale of pull-tabs and tipboards by the
148.6 distributor is imposed on the retail sales price. The retail sale of pull-tabs or tipboards by
148.7 the organization is exempt from taxes imposed by chapter 297A and is exempt from all
148.8 local taxes and license fees except a fee authorized under section 349.16, subdivision 8.

148.9 (c) One-half of one percent of the revenue deposited in the general fund under paragraph
148.10 (a), is appropriated to the commissioner of human services for the compulsive gambling
148.11 treatment program established under section 245.98. One-half of one percent of the revenue
148.12 deposited in the general fund under paragraph (a), is appropriated to the commissioner of
148.13 human services for a grant to the state affiliate recognized by the National Council on
148.14 Problem Gambling to increase public awareness of problem gambling, education and training
148.15 for individuals and organizations providing effective treatment services to problem gamblers
148.16 and their families, and research relating to problem gambling. Money appropriated by this
148.17 paragraph must supplement and must not replace existing state funding for these programs.
148.18 The balance of amounts appropriated under this paragraph that are unencumbered and
148.19 unspent at the close of a fiscal year must be available in the next fiscal year for the same
148.20 purposes and must not cancel to the fund from which the amounts were appropriated.

148.21 (d) The commissioner of human services must provide to the state affiliate recognized
148.22 by the National Council on Problem Gambling a monthly statement of the amounts deposited
148.23 under paragraph (c). Beginning January 1, 2022, the commissioner of human services must
148.24 provide to the chairs and ranking minority members of the legislative committees with
148.25 jurisdiction over treatment for problem gambling and to the state affiliate recognized by the
148.26 National Council on Problem Gambling an annual reconciliation of the amounts deposited
148.27 under paragraph (c). The annual reconciliation under this paragraph must include the amount
148.28 allocated to the commissioner of human services for the compulsive gambling treatment
148.29 program established under section 245.98, and the amount allocated to the state affiliate
148.30 recognized by the National Council on Problem Gambling. The annual reconciliation must
148.31 also include any rollover amounts from the previous fiscal year and the utilization of those
148.32 amounts during the current reporting period.

149.1 Sec. 24. Laws 2025, First Special Session chapter 9, article 4, section 2, the effective date,
149.2 is amended to read:

149.3 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

149.5 Sec. 25. Laws 2025, First Special Session chapter 9, article 4, section 23, the effective
149.6 date, is amended to read:

149.7 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

149.9 Sec. 26. Laws 2025, First Special Session chapter 9, article 4, section 38, the effective
149.10 date, is amended to read:

149.11 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

149.13 Sec. 27. Laws 2025, First Special Session chapter 9, article 4, section 39, the effective
149.14 date, is amended to read:

149.15 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

149.17 Sec. 28. Laws 2025, First Special Session chapter 9, article 4, section 40, the effective
149.18 date, is amended to read:

149.19 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

149.21 Sec. 29. Laws 2025, First Special Session chapter 9, article 4, section 41, the effective
149.22 date, is amended to read:

149.23 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

149.25 Sec. 30. Laws 2025, First Special Session chapter 9, article 4, section 42, the effective
149.26 date, is amended to read:

149.27 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

150.2 Sec. 31. Laws 2025, First Special Session chapter 9, article 4, section 43, the effective
150.3 date, is amended to read:

150.4 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

150.6 Sec. 32. Laws 2025, First Special Session chapter 9, article 4, section 44, the effective
150.7 date, is amended to read:

150.8 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

150.10 Sec. 33. Laws 2025, First Special Session chapter 9, article 4, section 50, the effective
150.11 date, is amended to read:

150.12 **EFFECTIVE DATE.** This section is effective ~~January~~ July 1, 2027 2026.

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

150.14 Sec. 34. **DIRECTION TO COMMISSIONER; CARCERAL TARGETED CASE**
150.15 **MANAGEMENT SERVICES BILLING UNITS.**

150.16 The commissioner of human services must establish a new billing code for carceral
150.17 targeted case management services. The commissioner must identify reimbursement rates
150.18 for the newly defined codes, as required under Minnesota Statutes, section 256B.0619,
150.19 subdivision 6. The new billing codes must correspond to a 15-minute unit and must be
150.20 available for 180 days postrelease.

150.21 **EFFECTIVE DATE.** This section is effective January 1, 2028, or upon federal approval,
150.22 whichever is later.

150.23 Sec. 35. **REPEALER.**

150.24 Minnesota Statutes 2024, section 256B.055, subdivision 14, is repealed.

150.25 **EFFECTIVE DATE.** This section is effective January 1, 2028, or upon federal approval,
150.26 whichever is later.

151.1

ARTICLE 5

151.2

UNIFORM SERVICE STANDARDS

151.3 Section 1. Minnesota Statutes 2024, section 245.735, subdivision 6, is amended to read:

151.4 Subd. 6. **Section 223 of the Protecting Access to Medicare Act entities.** ~~(a) The~~
151.5 ~~commissioner must request federal approval to participate in the demonstration program~~
151.6 ~~established by section 223 of the Protecting Access to Medicare Act and, if approved, to~~
151.7 ~~continue to participate in the demonstration program as long as federal funding for the~~
151.8 ~~demonstration program remains available from the United States Department of Health and~~
151.9 ~~Human Services. To the extent practicable, the commissioner shall align the requirements~~
151.10 ~~of the demonstration program with the requirements under this section for CCBHCs receiving~~
151.11 ~~medical assistance reimbursement under the authority of the state's Medicaid state plan. A~~
151.12 ~~CCBHC may not apply to participate as a billing provider in both the CCBHC federal~~
151.13 ~~demonstration and the benefit for CCBHCs under the medical assistance program.~~

151.14 ~~(b) The commissioner must follow federal payment guidance, including payment of the~~
151.15 ~~CCBHC daily bundled rate for services rendered by CCBHCs to individuals who are dually~~
151.16 ~~eligible for Medicare and medical assistance when Medicare is the primary payer for the~~
151.17 ~~service. Services provided by a CCBHC operating under the authority of the state's Medicaid~~
151.18 ~~state plan will not receive the prospective payment system rate for services rendered by~~
151.19 ~~CCBHCs to individuals who are dually eligible for Medicare and medical assistance when~~
151.20 ~~Medicare is the primary payer for the service.~~

151.21 ~~(e) Payment for services rendered by CCBHCs to individuals who have commercial~~
151.22 ~~insurance as the primary payer and medical assistance as secondary payer is subject to the~~
151.23 ~~requirements under section 256B.37. Services provided by a CCBHC operating under the~~
151.24 ~~authority of the 223 demonstration or the state's Medicaid state plan will not receive the~~
151.25 ~~prospective payment system rate for services rendered by CCBHCs to individuals who have~~
151.26 ~~commercial insurance as the primary payer and medical assistance as the secondary payer.~~

151.27 Sec. 2. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 2, is amended
151.28 to read:

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

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

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

- 152.1 (3) residential or nonresidential programs that are provided to adults who do not misuse
152.2 substances or have a substance use disorder, a mental illness, a developmental disability, a
152.3 functional impairment, or a physical disability;
- 152.4 (4) sheltered workshops or work activity programs that are certified by the commissioner
152.5 of employment and economic development;
- 152.6 (5) programs operated by a public school for children 33 months or older;
- 152.7 (6) nonresidential programs primarily for children that provide care or supervision for
152.8 periods of less than three hours a day while the child's parent or legal guardian is in the
152.9 same building as the nonresidential program or present within another building that is
152.10 directly contiguous to the building in which the nonresidential program is located;
- 152.11 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
152.12 under section 245A.02;
- 152.13 (8) board and lodge facilities licensed by the commissioner of health that do not provide
152.14 children's residential services under Minnesota Rules, chapter 2960, mental health or
152.15 substance use disorder treatment;
- 152.16 (9) programs licensed by the commissioner of corrections;
- 152.17 (10) recreation programs for children or adults that are operated or approved by a park
152.18 and recreation board whose primary purpose is to provide social and recreational activities;
- 152.19 (11) noncertified boarding care homes unless they provide services for five or more
152.20 persons whose primary diagnosis is mental illness or a developmental disability;
- 152.21 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art
152.22 programs, and nonresidential programs for children provided for a cumulative total of less
152.23 than 30 days in any 12-month period;
- 152.24 (13) residential programs for persons with mental illness, that are located in hospitals;
- 152.25 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter
152.26 4630;
- 152.27 (15) mental health outpatient services for adults with mental illness or children with
152.28 mental illness, except, effective January 1, 2028, for programs licensed under section
152.29 245A.044;
- 152.30 (16) residential programs serving school-age children whose sole purpose is cultural or
152.31 educational exchange, until the commissioner adopts appropriate rules;

153.1 (17) community support services programs as defined in section 245.462, subdivision
153.2 6, and family community support services as defined in section 245.4871, subdivision 17;

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

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

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

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

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

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

153.15 (22) a recovery community organization that is an eligible vendor under section
153.16 254B.0501 to provide peer recovery support services; or

153.17 (23) programs licensed by the commissioner of children, youth, and families in chapter
153.18 142B.

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

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

153.27 **EFFECTIVE DATE.** This section is effective January 1, 2028.

154.1 Sec. 3. **[245A.044] LICENSED NONRESIDENTIAL BEHAVIORAL HEALTH**
154.2 **SERVICES.**

154.3 **Subdivision 1. License required for certain nonresidential behavioral health**
154.4 **services. (a) Beginning January 1, 2028, providers of nonresidential mental health and**
154.5 **substance use disorder services must obtain a license under this chapter to provide:**

154.6 **(1) adult rehabilitative mental health services under section 245I.22;**

154.7 **(2) children's therapeutic services and supports in the community under section 245I.30**
154.8 **and children's day treatment under section 245I.31;**

154.9 **(3) crisis response services under section 245I.24; and**

154.10 **(4) certified community behavioral health clinic services under section 245I.17.**

154.11 **(b) As a condition of licensure, an applicant or license holder must demonstrate and**
154.12 **maintain verification of compliance with:**

154.13 **(1) licensing requirements under this chapter and chapter 245I; and**

154.14 **(2) applicable health care program requirements under Minnesota Rules, parts 9505.0170**
154.15 **to 9505.0475 and 9505.2160 to 9505.2245.**

154.16 **Subd. 2. Implementation. (a) Beginning July 1, 2027, the commissioner must begin**
154.17 **issuing licenses to providers listed in subdivision 1. The commissioner must transition**
154.18 **providers certified under section 245I.011 and listed in subdivision 1 into licensure with a**
154.19 **phased-in schedule determined by the commissioner. The commissioner must communicate**
154.20 **the implementation schedule to providers at least three months before the application is**
154.21 **made available.**

154.22 **(b) Applicants for licensure must have an approved certification under section 245I.011**
154.23 **at least 90 days before the date of the licensure application.**

154.24 **(c) A provider's certification under section 245I.011, subdivision 5, paragraph (a), clauses**
154.25 **(2) to (4), or 6, paragraph (b), expires when the commissioner issues a decision on the**
154.26 **provider's license application.**

154.27 **(d) Upon licensure, a license holder must notify clients and staff of policies and**
154.28 **procedures outlined in the application.**

154.29 **(e) Notwithstanding paragraphs (a) and (c), subdivision 1, and sections 245I.17, 245I.22,**
154.30 **245I.24, 245I.30, and 245I.31, a provider listed under subdivision 1, paragraph (a), clauses**
154.31 **(1) to (4), and certified under section 245I.011 may continue operating past January 1, 2028,**

155.1 until the commissioner issues a licensing decision if the provider submitted an application
155.2 before January 1, 2028.

155.3 (f) If a provider fails to submit an application for licensure within the time frame in
155.4 paragraph (b), the commissioner must disenroll the provider from reimbursement for the
155.5 following services:

155.6 (1) adult rehabilitative mental health services under section 256B.0623;

155.7 (2) crisis response services under section 256B.0624;

155.8 (3) children's therapeutic services and supports under section 256B.0943; and

155.9 (4) certified community behavioral health clinics under section 256B.0625, subdivision
155.10 5m.

155.11 (g) The commissioner must disenroll a provider listed in paragraph (f) from medical
155.12 assistance if:

155.13 (1) the provider's licensing application has been denied or the license has been suspended
155.14 or revoked; and

155.15 (2) the provider appealed the application denial or the license suspension or revocation,
155.16 and the commissioner issued a final order on the appeal affirming the action.

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

155.18 Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3, is amended
155.19 to read:

155.20 Subd. 3. **Application fee for initial license or certification.** (a) Except as provided in
155.21 paragraphs (c) ~~and~~, (d), and (f), for fees required under subdivision 1, an applicant for an
155.22 initial license or certification issued by the commissioner shall submit a \$2,100 application
155.23 fee with each new application required under this subdivision. The application fee shall not
155.24 be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that
155.25 expires on December 31. The commissioner shall not process an application until the
155.26 application fee is paid.

155.27 (b) Except as provided in paragraph (c), an applicant shall apply for a license to provide
155.28 services at a specific location.

155.29 (c) For a license to provide home and community-based services to persons with
155.30 disabilities or age 65 and older under chapter 245D, an applicant shall submit an application
155.31 to provide services statewide. For fees required under subdivision 1, an applicant for an

156.1 initial license issued by the commissioner to provide home and community-based services
 156.2 under chapter 245D shall submit a \$4,200 application fee with each new application.

156.3 (d) For fees required under subdivision 1, an applicant for an initial license or certification
 156.4 issued by the commissioner for children's residential facility ~~or mental health clinic licensure~~
 156.5 ~~or certification~~ shall submit a \$500 application fee with each new application required under
 156.6 this subdivision.

156.7 (e) For fees required under subdivision 1, an applicant for an initial mental health clinic
 156.8 certification issued by the commissioner shall submit a \$2,100 application fee with each
 156.9 new application required under this subdivision.

156.10 (f) For fees required under subdivision 1, an applicant for an initial license issued by
 156.11 the commissioner to provide services at a certified community behavioral health clinic under
 156.12 section 245I.17 shall submit a \$4,200 application fee with each new application.

156.13 Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended
 156.14 to read:

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

License Holder Annual Revenue	License Fee
156.21 less than or equal to \$10,000	\$250
156.22 greater than \$10,000 but less than or	
156.23 equal to \$25,000	\$375
156.24 greater than \$25,000 but less than or	
156.25 equal to \$50,000	\$500
156.26 greater than \$50,000 but less than or	
156.27 equal to \$100,000	\$625
156.28 greater than \$100,000 but less than or	
156.29 equal to \$150,000	\$750
156.30 greater than \$150,000 but less than or	
156.31 equal to \$200,000	\$1,000
156.32 greater than \$200,000 but less than or	
156.33 equal to \$250,000	\$1,250
156.34 greater than \$250,000 but less than or	
156.35 equal to \$300,000	\$1,500

157.1	greater than \$300,000 but less than or	
157.2	equal to \$350,000	\$1,750
157.3	greater than \$350,000 but less than or	
157.4	equal to \$400,000	\$2,000
157.5	greater than \$400,000 but less than or	
157.6	equal to \$450,000	\$2,250
157.7	greater than \$450,000 but less than or	
157.8	equal to \$500,000	\$2,500
157.9	greater than \$500,000 but less than or	
157.10	equal to \$600,000	\$2,850
157.11	greater than \$600,000 but less than or	
157.12	equal to \$700,000	\$3,200
157.13	greater than \$700,000 but less than or	
157.14	equal to \$800,000	\$3,600
157.15	greater than \$800,000 but less than or	
157.16	equal to \$900,000	\$3,900
157.17	greater than \$900,000 but less than or	
157.18	equal to \$1,000,000	\$4,250
157.19	greater than \$1,000,000 but less than or	
157.20	equal to \$1,250,000	\$4,550
157.21	greater than \$1,250,000 but less than or	
157.22	equal to \$1,500,000	\$4,900
157.23	greater than \$1,500,000 but less than or	
157.24	equal to \$1,750,000	\$5,200
157.25	greater than \$1,750,000 but less than or	
157.26	equal to \$2,000,000	\$5,500
157.27	greater than \$2,000,000 but less than or	
157.28	equal to \$2,500,000	\$5,900
157.29	greater than \$2,500,000 but less than or	
157.30	equal to \$3,000,000	\$6,200
157.31	greater than \$3,000,000 but less than or	
157.32	equal to \$3,500,000	\$6,500
157.33	greater than \$3,500,000 but less than or	
157.34	equal to \$4,000,000	\$7,200
157.35	greater than \$4,000,000 but less than or	
157.36	equal to \$4,500,000	\$7,800
157.37	greater than \$4,500,000 but less than or	
157.38	equal to \$5,000,000	\$9,000
157.39	greater than \$5,000,000 but less than or	
157.40	equal to \$7,500,000	\$10,000
157.41	greater than \$7,500,000 but less than or	
157.42	equal to \$10,000,000	\$14,000
157.43	greater than \$10,000,000 but less than or	
157.44	equal to \$12,500,000	\$18,000
157.45	greater than \$12,500,000 but less than or	
157.46	equal to \$15,000,000	\$25,000

158.1	greater than \$15,000,000 but less than or	
158.2	equal to \$17,500,000	\$28,000
158.3	greater than \$17,500,000 but less than	
158.4	\$20,000,000	\$32,000
158.5	greater than \$20,000,000 but less than	
158.6	\$25,000,000	\$36,000
158.7	greater than \$25,000,000 but less than	
158.8	\$30,000,000	\$45,000
158.9	greater than \$30,000,000 but less than	
158.10	\$35,000,000	\$55,000
158.11	greater than \$35,000,000	\$75,000

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

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

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

158.20 (b) A substance use disorder treatment program licensed under chapter 245G, to provide
 158.21 substance use disorder treatment shall pay an annual nonrefundable license fee based on
 158.22 the following schedule:

158.23	Licensed Capacity	License Fee
158.24	1 to 24 persons	\$2,600
158.25	25 to 49 persons	\$3,000
158.26	50 to 74 persons	\$5,000
158.27	75 to 99 persons	\$10,000
158.28	100 to 199 persons	\$15,000
158.29	200 or more persons	\$20,000

158.30 (c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to
 158.31 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay
 158.32 an annual nonrefundable license fee based on the following schedule:

158.33	Licensed Capacity	License Fee
158.34	1 to 24 persons	\$2,600
158.35	25 to 49 persons	\$3,000
158.36	50 or more persons	\$5,000

159.1 A detoxification program that also operates a withdrawal management program at the same
 159.2 location shall only pay one fee based upon the licensed capacity of the program with the
 159.3 higher overall capacity.

159.4 (d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to
 159.5 serve children shall pay an annual nonrefundable license fee based on the following schedule:

159.6	Licensed Capacity	License Fee
159.7	1 to 24 persons	\$1,000
159.8	25 to 49 persons	\$1,100
159.9	50 to 74 persons	\$1,200
159.10	75 to 99 persons	\$1,300
159.11	100 or more persons	\$1,400

159.12 (e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts
 159.13 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual
 159.14 nonrefundable license fee based on the following schedule:

159.15	Licensed Capacity	License Fee
159.16	1 to 24 persons	\$2,600
159.17	25 to 49 persons	\$3,000
159.18	50 or more persons	\$20,000

159.19 (f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400,
 159.20 to serve persons with physical disabilities shall pay an annual nonrefundable license fee
 159.21 based on the following schedule:

159.22	Licensed Capacity	License Fee
159.23	1 to 24 persons	\$450
159.24	25 to 49 persons	\$650
159.25	50 to 74 persons	\$850
159.26	75 to 99 persons	\$1,050
159.27	100 or more persons	\$1,250

159.28 (g) A program licensed as an adult day care center licensed under Minnesota Rules,
 159.29 parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the
 159.30 following schedule:

159.31	Licensed Capacity	License Fee
159.32	1 to 24 persons	\$2,600
159.33	25 to 49 persons	\$3,000
159.34	50 to 74 persons	\$5,000

160.1	75 to 99 persons	\$10,000
160.2	100 to 199 persons	\$15,000
160.3	200 or more persons	\$20,000

160.4 (h) A program licensed to provide treatment services to persons with sexual psychopathic
160.5 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
160.6 9515.3110, shall pay an annual nonrefundable license fee of \$20,000.

160.7 (i) A mental health clinic certified under section 245I.20 shall pay an annual
160.8 nonrefundable certification fee of ~~\$1,550~~ \$3,000. If the mental health clinic provides services
160.9 at a primary location with satellite facilities, the satellite facilities shall be certified with the
160.10 primary location without an additional charge.

160.11 ~~(j) If a program subject to annual fees under paragraph (b) provides services at a primary~~
160.12 ~~location with satellite facilities, the satellite facilities must be licensed with the primary~~
160.13 ~~location and must be subject to an additional \$500 annual nonrefundable license fee per~~
160.14 ~~satellite facility.~~

160.15 (j) A program licensed to provide behavioral health treatment services licensed under
160.16 section 245I.22, 245I.24, 245I.30, or 245I.31 shall pay an annual nonrefundable license fee
160.17 of \$3,000 for each license.

160.18 (k) Certified community behavioral health clinics licensed under section 245I.17 shall
160.19 pay an annual nonrefundable license fee of \$7,800.

160.20 Sec. 6. Minnesota Statutes 2024, section 245A.10, is amended by adding a subdivision to
160.21 read:

160.22 Subd. 4a. Fees for satellite locations. (a) If a program subject to annual fees under
160.23 subdivision 4, paragraph (b), provides services at a primary location with satellite facilities,
160.24 the satellite facilities are licensed with the primary location and are subject to an additional
160.25 \$500 annual nonrefundable license fee per satellite facility.

160.26 (b) If a program subject to annual fees under subdivision 4, paragraph (j), provides
160.27 services at a primary location with satellite sites or facilities, the satellite locations must be
160.28 licensed with the primary location and are subject to an additional annual nonrefundable
160.29 fee according to the following schedule:

160.30 (1) one to five satellite locations: \$1,500;

160.31 (2) six to 19 satellite locations: \$3,500; or

160.32 (3) 20 or more satellite locations: \$5,000.

161.1 Sec. 7. Minnesota Statutes 2024, section 245A.65, subdivision 1a, is amended to read:

161.2 Subd. 1a. **Determination of vulnerable adult status.** (a) A license holder that provides
161.3 services to adults who are excluded from the definition of vulnerable adult under section
161.4 626.5572, subdivision 21, paragraph (a), clause (2), must determine whether the person is
161.5 a vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (4). This
161.6 determination must be made within 24 hours of:

161.7 (1) admission to the licensed program; and

161.8 (2) any incident that:

161.9 (i) was reported under section 626.557; or

161.10 (ii) would have been required to be reported under section 626.557, if one or more of
161.11 the adults involved in the incident had been vulnerable adults.

161.12 (b) Upon determining that a person receiving services is a vulnerable adult under section
161.13 626.5572, subdivision 21, paragraph (a), clause (4), all requirements relative to vulnerable
161.14 adults under this chapter and section 626.557 must be met by the license holder.

161.15 (c) Notwithstanding paragraph (a), clause (1), a license holder providing mobile crisis
161.16 services must make the required determination within 24 hours of first providing crisis
161.17 stabilization services to an adult under section 245I.24, subdivision 9.

161.18 Sec. 8. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

161.19 Subdivision 1. **Programs licensed by the commissioner.** (a) The commissioner shall
161.20 conduct a background study on:

161.21 (1) the person or persons applying for a license;

161.22 (2) an individual age 13 and over living in the household where the licensed program
161.23 will be provided who is not receiving licensed services from the program;

161.24 (3) current or prospective employees of the applicant or license holder who will have
161.25 direct contact with persons served by the facility, agency, or program;

161.26 (4) volunteers or student volunteers who will have direct contact with persons served
161.27 by the program to provide program services if the contact is not under the continuous, direct
161.28 supervision by an individual listed in clause (1) or (3);

161.29 (5) an individual age ten to 12 living in the household where the licensed services will
161.30 be provided when the commissioner has reasonable cause as defined in section 245C.02,
161.31 subdivision 15;

162.1 (6) an individual who, without providing direct contact services at a licensed program,
162.2 may have unsupervised access to children or vulnerable adults receiving services from a
162.3 program, when the commissioner has reasonable cause as defined in section 245C.02,
162.4 subdivision 15; and

162.5 (7) all controlling individuals as defined in section 245A.02, subdivision 5a;

162.6 (8) notwithstanding clause (3), for children's residential facilities and foster residence
162.7 settings, any adult working in the facility, whether or not the individual will have direct
162.8 contact with persons served by the facility.

162.9 (b) For child foster care when the license holder resides in the home where foster care
162.10 services are provided, a short-term substitute caregiver providing direct contact services for
162.11 a child for less than 72 hours of continuous care is not required to receive a background
162.12 study under this chapter.

162.13 (c) This subdivision applies to the following programs that must be licensed under
162.14 chapter 245A:

162.15 (1) adult foster care;

162.16 (2) children's residential facilities;

162.17 (3) licensed home and community-based services under chapter 245D;

162.18 (4) residential mental health programs for adults;

162.19 (5) substance use disorder treatment programs under chapter 245G;

162.20 (6) withdrawal management programs under chapter 245F;

162.21 (7) adult day care centers;

162.22 (8) family adult day services;

162.23 (9) detoxification programs;

162.24 (10) community residential settings;

162.25 (11) intensive residential treatment services and residential crisis stabilization under
162.26 chapter 245I; ~~and~~

162.27 (12) treatment programs for persons with sexual psychopathic personality or sexually
162.28 dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts
162.29 9515.3000 to 9515.3110; ;

162.30 (13) adult rehabilitative mental health services under chapter 245I;

- 163.1 (14) certified community behavioral health clinic services under chapter 245I;
163.2 (15) children's therapeutic services and supports under chapter 245I; and
163.3 (16) crisis response services under chapter 245I.

163.4 Sec. 9. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended
163.5 to read:

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

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

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

163.11 (i) the individual is not disqualified; or

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

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

163.22 (3) a notice that a variance has been granted related to the individual under section
163.23 245C.30.

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

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

- 164.1 (1) being issued a license;
- 164.2 (2) living in the household where the licensed program will be provided;
- 164.3 (3) providing direct contact services to persons served by a program unless the subject
164.4 is under continuous direct supervision;
- 164.5 (4) having access to persons receiving services if the background study was completed
164.6 under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2),
164.7 (5), or (6), unless the subject is under continuous direct supervision;
- 164.8 (5) for licensed child care centers and certified license-exempt child care centers,
164.9 providing direct contact services to persons served by the program;
- 164.10 (6) for children's residential facilities or foster residence settings, working in the facility
164.11 or setting;
- 164.12 (7) for background studies affiliated with a personal care provider organization, except
164.13 as provided in section 245C.03, subdivision 3b, or with an early intensive developmental
164.14 and behavioral intervention provider or adult rehabilitative mental health services provider,
164.15 ~~before a personal care assistant~~ an individual provides services, the ~~personal care assistance~~
164.16 ~~provider agency entity~~ must initiate a background study of the ~~personal care assistant~~
164.17 individual under this chapter and the ~~personal care assistance provider agency entity~~ must
164.18 have received a notice from the commissioner that the ~~personal care assistant~~ individual is:
- 164.19 (i) not disqualified under section 245C.14; or
- 164.20 (ii) disqualified, but the personal care assistant has received a set aside of the
164.21 disqualification under section 245C.22; or
- 164.22 (8) for background studies affiliated with an early intensive developmental and behavioral
164.23 intervention provider, before an individual provides services, the early intensive
164.24 developmental and behavioral intervention provider must initiate a background study for
164.25 the individual under this chapter and the early intensive developmental and behavioral
164.26 intervention provider must have received a notice from the commissioner that the individual
164.27 is:
- 164.28 (i) not disqualified under section 245C.14; or
- 164.29 (ii) disqualified, but the individual has received a set-aside of the disqualification under
164.30 section 245C.22.

165.1 Sec. 10. Minnesota Statutes 2025 Supplement, section 245C.16, subdivision 1, is amended
165.2 to read:

165.3 Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines
165.4 that the individual studied has a disqualifying characteristic, the commissioner shall review
165.5 the information immediately available and make a determination as to the subject's immediate
165.6 risk of harm to persons served by the program where the individual studied will have direct
165.7 contact with, or access to, people receiving services.

165.8 (b) The commissioner shall consider all relevant information available, including the
165.9 following factors in determining the immediate risk of harm:

165.10 (1) the recency of the disqualifying characteristic;

165.11 (2) the recency of discharge from probation for the crimes;

165.12 (3) the number of disqualifying characteristics;

165.13 (4) the intrusiveness or violence of the disqualifying characteristic;

165.14 (5) the vulnerability of the victim involved in the disqualifying characteristic;

165.15 (6) the similarity of the victim to the persons served by the program where the individual
165.16 studied will have direct contact;

165.17 (7) whether the individual has a disqualification from a previous background study that
165.18 has not been set aside;

165.19 (8) if the individual has a disqualification which may not be set aside because it is a
165.20 permanent bar under section 245C.24, subdivision 1, or the individual is a child care
165.21 background study subject who has a felony-level conviction for a drug-related offense in
165.22 the last five years, the commissioner may order the immediate removal of the individual
165.23 from any position allowing direct contact with, or access to, persons receiving services from
165.24 the program and from working in a children's residential facility or foster residence setting;
165.25 and

165.26 (9) if the individual has a disqualification which may not be set aside because it is a
165.27 permanent bar under section 245C.24, subdivision 2, or the individual is a child care
165.28 background study subject who has a felony-level conviction for a drug-related offense during
165.29 the last five years, the commissioner may order the immediate removal of the individual
165.30 from any position allowing direct contact with or access to persons receiving services from
165.31 the center and from working in a licensed child care center or certified license-exempt child
165.32 care center.

166.1 (c) This section does not apply when the subject of a background study is regulated by
 166.2 a health-related licensing board as defined in chapter 214, and the subject is determined to
 166.3 be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

166.4 (d) This section does not apply to a background study related to an initial application
 166.5 for a child foster family setting license.

166.6 (e) Except for paragraph (f), this section does not apply to a background study that is
 166.7 also subject to the requirements under section ~~256B.0659, subdivisions 11 and 13, for a~~
 166.8 ~~personal care assistant or a qualified professional as defined in section 256B.0659,~~
 166.9 ~~subdivision 1, or to a background study for an individual providing early intensive~~
 166.10 ~~developmental and behavioral intervention services under section 256B.0949~~ 245C.13,
 166.11 subdivision 2, paragraph (c), clause (7).

166.12 (f) If the commissioner has reason to believe, based on arrest information or an active
 166.13 maltreatment investigation, that an individual poses an imminent risk of harm to persons
 166.14 receiving services, the commissioner may order that the person be continuously supervised
 166.15 or immediately removed pending the conclusion of the maltreatment investigation or criminal
 166.16 proceedings.

166.17 Sec. 11. Minnesota Statutes 2024, section 245G.03, subdivision 1, is amended to read:

166.18 Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance
 166.19 use disorder treatment must comply with the general requirements in section 626.557;
 166.20 chapters 245A, 245C, and 260E; and Minnesota Rules, chapter 9544.

166.21 (b) The commissioner may grant variances to the requirements in this chapter that do
 166.22 not affect the client's health or safety if the conditions in section 245A.04, subdivision 9,
 166.23 are met.

166.24 (c) If a program is licensed according to this chapter and is part of a certified community
 166.25 behavioral health clinic under section ~~245.735~~ 245I.17, the license holder must comply with
 166.26 the requirements in section ~~245.735~~ 245I.17, subdivisions ~~4b to 4e~~ 12 and 13, as part of the
 166.27 licensing requirements under this chapter.

166.28 Sec. 12. Minnesota Statutes 2024, section 245I.011, subdivision 3, is amended to read:

166.29 Subd. 3. **Certification required.** (a) An individual, organization, or government entity
 166.30 that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause
 166.31 ~~(12)~~ (15), and chooses to be identified as a certified mental health clinic must:

166.32 (1) be a mental health clinic that is certified under section 245I.20;

167.1 (2) comply with all of the responsibilities assigned to a license holder by this chapter
 167.2 except subdivision 1; and

167.3 (3) comply with all of the responsibilities assigned to a certification holder by chapter
 167.4 245A.

167.5 (b) An individual, organization, or government entity described by this subdivision must
 167.6 obtain a criminal background study for each staff person or volunteer who provides direct
 167.7 contact services to clients.

167.8 ~~(c) If a clinic is certified according to this chapter and is part of a certified community~~
 167.9 ~~behavioral health clinic under section 245.735, the license holder must comply with the~~
 167.10 ~~requirements in section 245.735, subdivisions 4b to 4e, as part of the licensing requirements~~
 167.11 ~~under this chapter.~~

167.12 **EFFECTIVE DATE.** This section is effective the day following final enactment, except
 167.13 the amendment striking paragraph (c) is effective January 1, 2028.

167.14 Sec. 13. Minnesota Statutes 2024, section 245I.011, subdivision 5, is amended to read:

167.15 Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or
 167.16 government entity certified under the following sections must comply with all of the
 167.17 responsibilities assigned to a license holder under this chapter except subdivision 1:

167.18 (1) an assertive community treatment provider under section 256B.0622, subdivision
 167.19 3a;

167.20 ~~(2) an adult rehabilitative mental health services provider under section 256B.0623;~~

167.21 ~~(3) a mobile crisis team under section 256B.0624;~~

167.22 ~~(4) a children's therapeutic services and supports provider under section 256B.0943;~~

167.23 ~~(5)~~ (2) a children's intensive behavioral health services provider under section 256B.0946;

167.24 and

167.25 ~~(6)~~ (3) an intensive nonresidential rehabilitative mental health services provider under
 167.26 section 256B.0947.

167.27 (b) An individual, organization, or government entity certified under the sections listed
 167.28 in paragraph (a), ~~clauses (1) to (6)~~, must obtain a criminal background study for each staff
 167.29 person and volunteer providing direct contact services to a client.

167.30 **EFFECTIVE DATE.** This section is effective January 1, 2028.

168.1 Sec. 14. Minnesota Statutes 2024, section 245I.011, is amended by adding a subdivision
168.2 to read:

168.3 Subd. 6. License required for nonresidential programs. (a) Beginning January 1,
168.4 2028, an individual, organization, or government entity must have a license under this
168.5 chapter to provide the following services:

168.6 (1) adult rehabilitative mental health services, as defined in section 256B.0623;

168.7 (2) mobile crisis services, as defined in section 256B.0624;

168.8 (3) children's therapeutic services and supports, as defined in section 256B.0943; or

168.9 (4) certified community behavioral health clinic services, as defined in sections 245I.17
168.10 and 256B.0625, subdivision 5m.

168.11 (b) An individual, organization, or government entity certified as any of the following
168.12 must remain certified according to subdivision 5 until the commissioner issues a license,
168.13 the commissioner denies the license application, or the certification expires according to
168.14 chapter 245A:

168.15 (1) an adult rehabilitative mental health services provider under section 256B.0623;

168.16 (2) a mobile crisis team under section 256B.0624;

168.17 (3) a children's therapeutic services and supports provider under section 256B.0943; or

168.18 (4) a certified community behavioral health clinic under section 245.735.

168.19 Sec. 15. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
168.20 to read:

168.21 Subd. 1a. Alcohol and drug counselor "Alcohol and drug counselor" means an individual
168.22 qualified under section 245G.11, subdivision 5.

168.23 Sec. 16. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
168.24 to read:

168.25 Subd. 10a. Comprehensive evaluation. "Comprehensive evaluation" means a
168.26 person-centered, family-centered, and trauma-informed evaluation conducted according to
168.27 section 245I.17, subdivision 12.

169.1 Sec. 17. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
169.2 to read:

169.3 Subd. 18a. **Initial evaluation.** "Initial evaluation" means the assessment and preliminary
169.4 diagnosis necessary to begin client services, conducted according to section 245I.17.

169.5 Sec. 18. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
169.6 to read:

169.7 Subd. 31a. **Psychotherapy.** "Psychotherapy" has the meaning given in section 256B.0671,
169.8 subdivision 11.

169.9 Sec. 19. Minnesota Statutes 2024, section 245I.02, subdivision 33, is amended to read:

169.10 **Subd. 33. Rehabilitative mental health services.** "Rehabilitative mental health services"
169.11 means mental health services provided to ~~an adult~~ a client that enable the client to develop
169.12 and achieve psychiatric stability, social competencies, personal and emotional adjustment,
169.13 independent living skills, family roles, and community skills when symptoms of mental
169.14 illness has impaired any of the client's abilities in these areas. Rehabilitative mental health
169.15 services include interventions that allow a client to self-monitor, compensate for, counteract,
169.16 or replace psychosocial skills deficits or maladaptive skills acquired over the course of a
169.17 mental illness. For a child client, rehabilitative mental health services include interventions
169.18 to restore a child or adolescent to an age-appropriate developmental trajectory that has been
169.19 disrupted by a mental illness.

169.20 Sec. 20. Minnesota Statutes 2024, section 245I.02, subdivision 39, is amended to read:

169.21 **Subd. 39. Treatment plan.** "Treatment plan" means services that a license holder
169.22 formulates to respond to a client's needs and goals. A treatment plan includes individual
169.23 treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under
169.24 section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision
169.25 8, and ~~256B.0624, subdivision 11~~ 245I.24, subdivision 11. For a license holder under section
169.26 245I.17, a treatment plan is the integrated treatment plan developed according to section
169.27 245I.17, subdivision 13.

169.28 Sec. 21. Minnesota Statutes 2024, section 245I.03, subdivision 4, is amended to read:

169.29 **Subd. 4. Behavioral emergencies.** (a) A license holder must have procedures that each
169.30 staff person follows when responding to a client who exhibits behavior that threatens the

170.1 immediate safety of the client or others. A license holder's behavioral emergency procedures
170.2 must incorporate person-centered planning and trauma-informed care.

170.3 (b) A license holder's behavioral emergency procedures must include:

170.4 (1) a plan designed to prevent the client from inflicting self-harm and harming others;

170.5 (2) contact information for emergency resources that a staff person must use when the
170.6 license holder's behavioral emergency procedures are unsuccessful in controlling a client's
170.7 behavior;

170.8 (3) the types of behavioral emergency procedures that a staff person may use;

170.9 (4) the specific circumstances under which the program may use behavioral emergency
170.10 procedures; ~~and~~

170.11 (5) the staff persons whom the license holder authorizes to implement behavioral
170.12 emergency procedures; and

170.13 (6) the contact information for the local crisis team.

170.14 (c) The license holder's behavioral emergency procedures must not include secluding
170.15 or restraining a client except as allowed under section 245.8261.

170.16 (d) Staff persons must not use behavioral emergency procedures to enforce program
170.17 rules or for the convenience of staff persons. Behavioral emergency procedures must not
170.18 be part of any client's treatment plan. A staff person may not use behavioral emergency
170.19 procedures except in response to a client's current behavior that threatens the immediate
170.20 safety of the client or others.

170.21 Sec. 22. Minnesota Statutes 2024, section 245I.03, is amended by adding a subdivision
170.22 to read:

170.23 Subd. 11. **Quality assurance and improvement plan.** (a) At a minimum, a license
170.24 holder must develop a written quality assurance and improvement plan that includes plans
170.25 for:

170.26 (1) encouraging ongoing consultation among members of the treatment team;

170.27 (2) obtaining and evaluating feedback about services from clients, family and other
170.28 natural supports, referral sources, and staff persons;

170.29 (3) measuring and evaluating client outcomes;

170.30 (4) reviewing client suicide deaths and suicide attempts;

171.1 (5) examining the quality of clinical service delivery to clients; and

171.2 (6) self-monitoring of compliance with this chapter.

171.3 (b) At least annually, a license holder must review, evaluate, and update the quality
171.4 assurance and improvement plan. The review must:

171.5 (1) include documentation of the actions that the certification holder will take as a result
171.6 of information obtained from monitoring activities in the plan; and

171.7 (2) establish goals for improved service delivery to clients for the next year.

171.8 Sec. 23. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 5, is amended
171.9 to read:

171.10 Subd. 5. **Behavioral health practitioner scope of practice.** (a) A behavioral health
171.11 practitioner under the treatment supervision of a mental health professional or certified
171.12 rehabilitation specialist may provide an adult client with client education, rehabilitative
171.13 mental health services, functional assessments, level of care assessments, crisis planning,
171.14 and treatment plans. A behavioral health practitioner under the treatment supervision of a
171.15 mental health professional may provide skill-building services ~~to a child client,~~ crisis
171.16 planning, and complete treatment plans for a child client.

171.17 (b) A behavioral health practitioner must not provide treatment supervision to other staff
171.18 persons. A behavioral health practitioner may provide direction to mental health rehabilitation
171.19 workers and mental health behavioral aides.

171.20 (c) A behavioral health practitioner who provides services to clients according to section
171.21 256B.0624 may perform crisis assessments and interventions for a client.

171.22 Sec. 24. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, is amended
171.23 to read:

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

171.29 Sec. 25. Minnesota Statutes 2024, section 245I.06, subdivision 1, is amended to read:

171.30 Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health
171.31 professional or certified rehabilitation specialist provides treatment supervision to each staff

172.1 person who provides services to a client and who is not a mental health professional or
172.2 certified rehabilitation specialist. When providing treatment supervision, a treatment
172.3 supervisor must follow a staff person's written treatment supervision plan.

172.4 (b) Treatment supervision must focus on each client's treatment needs and the ability of
172.5 the staff person under treatment supervision to provide services to each client, including
172.6 the following topics related to the staff person's current caseload:

172.7 (1) a review and evaluation of the interventions that the staff person delivers to each
172.8 client;

172.9 (2) instruction on alternative strategies if a client is not achieving treatment goals;

172.10 (3) a review and evaluation of each client's assessments, treatment plans, and progress
172.11 notes for accuracy and appropriateness;

172.12 (4) instruction on the cultural norms or values of the clients and communities that the
172.13 license holder serves and the impact that a client's culture has on providing treatment;

172.14 (5) evaluation of and feedback regarding a direct service staff person's areas of
172.15 competency; ~~and~~

172.16 (6) coaching, teaching, and practicing skills with a staff person; and

172.17 (7) modeling service practices that respect the client, include the client in planning and
172.18 implementation of the individual treatment plan, recognize the client's strengths, and
172.19 coordinate with other involved parties and providers.

172.20 (c) A treatment supervisor must provide treatment supervision to a staff person using
172.21 methods that allow for immediate feedback, including in-person, telephone, and interactive
172.22 video supervision.

172.23 (d) A treatment supervisor's responsibility for a staff person receiving treatment
172.24 supervision is limited to the services provided by the associated license holder. If a staff
172.25 person receiving treatment supervision is employed by multiple license holders, each license
172.26 holder is responsible for providing treatment supervision related to the treatment of the
172.27 license holder's clients.

172.28 Sec. 26. Minnesota Statutes 2024, section 245I.06, subdivision 2, is amended to read:

172.29 Subd. 2. **Treatment supervision planning.** (a) A treatment supervisor and the staff
172.30 person supervised by the treatment supervisor must develop a written treatment supervision
172.31 plan. The license holder must ensure that a new staff person's treatment supervision plan is
172.32 completed, approved by the staff person, and implemented by a treatment supervisor and

173.1 the new staff person within 30 days of the new staff person's first day of employment. The
173.2 license holder must review and update each staff person's treatment supervision plan annually.

173.3 (b) Each staff person's treatment supervision plan must include:

173.4 (1) the name and qualifications of the staff person receiving treatment supervision;

173.5 (2) the names and licensures of the treatment supervisors who are supervising the staff
173.6 person;

173.7 (3) how frequently the treatment supervisors must provide treatment supervision to the
173.8 staff person; and

173.9 (4) the staff person's authorized scope of practice, including a description of the client
173.10 ~~population~~ ages that the staff person serves, and a description of the treatment methods and
173.11 modalities that the staff person may use to provide services to clients.

173.12 Sec. 27. Minnesota Statutes 2024, section 245I.07, is amended to read:

173.13 **245I.07 PERSONNEL FILES.**

173.14 (a) For each staff person, a license holder must maintain a personnel file that includes:

173.15 (1) verification of the staff person's qualifications required for the position including
173.16 training, education, practicum or internship agreement, licensure, and any other required
173.17 qualifications;

173.18 (2) documentation related to the staff person's background study;

173.19 (3) the hiring date of the staff person;

173.20 (4) a description of the staff person's job responsibilities with the license holder;

173.21 (5) the date that the staff person's specific duties and responsibilities became effective,
173.22 including the date that the staff person began having direct contact with clients;

173.23 (6) documentation of the staff person's training as required by section 245I.05, subdivision
173.24 2;

173.25 (7) a verification copy of license renewals that the staff person completed during the
173.26 staff person's employment;

173.27 (8) annual job performance evaluations; and

173.28 (9) if applicable, the staff person's alleged and substantiated violations of the license
173.29 holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license
173.30 holder's response.

174.1 (b) The license holder must ensure that all personnel files are readily accessible for the
174.2 commissioner's review. The license holder is not required to keep personnel files in a single
174.3 location.

174.4 (c) For a license holder under section 245I.17, a personnel file for staff who provide
174.5 substance use disorder treatment services must include records of training required under
174.6 section 245G.13, subdivision 2.

174.7 Sec. 28. Minnesota Statutes 2024, section 245I.10, is amended by adding a subdivision
174.8 to read:

174.9 Subd. 2a. **Evaluation, treatment authorization, and planning in a certified community**
174.10 **behavioral health clinic.** Notwithstanding subdivisions 2 and 7, a license holder under
174.11 section 245I.17 must meet the requirements for assessments under section 245I.17,
174.12 subdivisions 11 and 12, and for treatment planning under section 245I.17, subdivision 13.
174.13 Certified community behavioral health clinic service planning and authorization must comply
174.14 with the standards in section 245I.17.

174.15 Sec. 29. Minnesota Statutes 2024, section 245I.10, subdivision 6, is amended to read:

174.16 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health
174.17 professional or a clinical trainee may complete a standard diagnostic assessment of a client.
174.18 A standard diagnostic assessment of a client must include a face-to-face interview with a
174.19 client and a written evaluation of the client. The assessor must complete a client's standard
174.20 diagnostic assessment within the client's cultural context. An alcohol and drug counselor
174.21 may gather and document the information in paragraphs (b) and (c) when completing a
174.22 comprehensive assessment according to section 245G.05.

174.23 (b) When completing a standard diagnostic assessment of a client, the assessor must
174.24 gather and document information about the client's current life situation, including the
174.25 following information:

174.26 (1) the client's age;

174.27 (2) the client's current living situation, including the client's housing status and household
174.28 members;

174.29 (3) the status of the client's basic needs;

174.30 (4) the client's education level and employment status;

174.31 (5) the client's current medications;

- 175.1 (6) any immediate risks to the client's health and safety, including withdrawal symptoms,
175.2 medical conditions, and behavioral and emotional symptoms;
- 175.3 (7) the client's perceptions of the client's condition;
- 175.4 (8) the client's description of the client's symptoms, including the reason for the client's
175.5 referral;
- 175.6 (9) the client's history of mental health and substance use disorder treatment;
- 175.7 (10) cultural influences on the client; and
- 175.8 (11) substance use history, if applicable, including:
- 175.9 (i) amounts and types of substances, frequency and duration, route of administration,
175.10 periods of abstinence, and circumstances of relapse; and
- 175.11 (ii) the impact to functioning when under the influence of substances, including legal
175.12 interventions.
- 175.13 (c) If the assessor cannot obtain the information that this paragraph requires without
175.14 retraumatizing the client or harming the client's willingness to engage in treatment, the
175.15 assessor must identify which topics will require further assessment during the course of the
175.16 client's treatment. The assessor must gather and document information related to the following
175.17 topics:
- 175.18 (1) the client's relationship with the client's family and other significant personal
175.19 relationships, including the client's evaluation of the quality of each relationship;
- 175.20 (2) the client's strengths and resources, including the extent and quality of the client's
175.21 social networks;
- 175.22 (3) important developmental incidents in the client's life;
- 175.23 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;
- 175.24 (5) the client's history of or exposure to alcohol and drug usage and treatment; and
- 175.25 (6) the client's health history and the client's family health history, including the client's
175.26 physical, chemical, and mental health history.
- 175.27 (d) When completing a standard diagnostic assessment of a client, an assessor must use
175.28 a recognized diagnostic framework.
- 175.29 (1) When completing a standard diagnostic assessment of a client who is five years of
175.30 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic

176.1 Classification of Mental Health and Development Disorders of Infancy and Early Childhood
176.2 published by Zero to Three.

176.3 (2) When completing a standard diagnostic assessment of a client who is six years of
176.4 age or older, the assessor must use the current edition of the Diagnostic and Statistical
176.5 Manual of Mental Disorders published by the American Psychiatric Association.

176.6 (3) When completing a standard diagnostic assessment of a client who is 12 to 17 years
176.7 of age, an assessor must use either the CRAFFT Questionnaire or the criteria in the most
176.8 recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by
176.9 the American Psychiatric Association to screen and assess the client for a substance use
176.10 disorder.

176.11 ~~(3)~~ (4) When completing a standard diagnostic assessment of a client who is 18 years
176.12 of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the
176.13 criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental
176.14 Disorders published by the American Psychiatric Association to screen and assess the client
176.15 for a substance use disorder.

176.16 (e) When completing a standard diagnostic assessment of a client, the assessor must
176.17 include and document the following components of the assessment:

176.18 (1) the client's mental status examination;

176.19 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;
176.20 vulnerabilities; safety needs, including client information that supports the assessor's findings
176.21 after applying a recognized diagnostic framework from paragraph (d); and any differential
176.22 diagnosis of the client; and

176.23 (3) an explanation of: (i) how the assessor diagnosed the client using the information
176.24 from the client's interview, assessment, psychological testing, and collateral information
176.25 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;
176.26 and (v) the client's responsivity factors.

176.27 (f) When completing a standard diagnostic assessment of a client, the assessor must
176.28 consult the client and the client's family about which services that the client and the family
176.29 prefer to treat the client. ~~The assessor must make referrals for the client as to services required~~
176.30 ~~by law.~~

176.31 (g) Information from other providers and prior assessments may be used to complete
176.32 the diagnostic assessment if the source of the information is documented in the diagnostic
176.33 assessment.

177.1 (h) If the client screens positive for a need for substance use disorder treatment services,
177.2 the assessor must document what actions will be taken to address the client's co-occurring
177.3 conditions.

177.4 (i) The assessor must determine if the client is eligible for targeted case management
177.5 services according to section 245.462, subdivision 20, or 245.4871, subdivision 6, and refer
177.6 the client to the county or contracted provider as appropriate.

177.7 Sec. 30. Minnesota Statutes 2024, section 245I.10, subdivision 8, is amended to read:

177.8 Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's
177.9 diagnostic assessment or reviewing a client's diagnostic assessment received from a different
177.10 provider and before providing services to the client beyond those permitted under subdivision
177.11 7, the license holder must complete the client's individual treatment plan. The license holder
177.12 must:

177.13 (1) base the client's individual treatment plan on the client's diagnostic assessment and
177.14 baseline measurements;

177.15 (2) for a child client, use a child-centered, family-driven, and culturally appropriate
177.16 planning process that allows the child's parents and guardians to observe and participate in
177.17 the child's individual and family treatment services, assessments, and treatment planning;

177.18 (3) for an adult client, use a person-centered, culturally appropriate planning process
177.19 that allows the client's family and other natural supports to observe and participate in the
177.20 client's treatment services, assessments, and treatment planning;

177.21 (4) identify the client's treatment goals, measureable treatment objectives, a schedule
177.22 for accomplishing the client's treatment goals and objectives, a treatment strategy, and the
177.23 individuals responsible for providing treatment services and supports to the client. The
177.24 license holder must have a treatment strategy to engage the client in treatment if the client:

177.25 (i) has a history of not engaging in treatment; and

177.26 (ii) is ordered by a court to participate in treatment services or to take neuroleptic
177.27 medications;

177.28 (5) identify the participants involved in the client's treatment planning. The client must
177.29 be a participant in the client's treatment planning. If applicable, the license holder must
177.30 document the reasons that the license holder did not involve the client's family, case manager,
177.31 or other natural supports in the client's treatment planning; and

178.1 ~~(6) review the client's individual treatment plan every 180 days and update the client's~~
178.2 ~~individual treatment plan with the client's treatment progress, new treatment objectives and~~
178.3 ~~goals or, if the client has not made treatment progress, changes in the license holder's~~
178.4 ~~approach to treatment; and~~

178.5 ~~(7)~~ (6) ensure that the client approves of the client's individual treatment plan unless a
178.6 court orders the client's treatment plan under chapter 253B.

178.7 (b) If the client disagrees with the client's treatment plan, the license holder must
178.8 document in the client file the reasons why the client does not agree with the treatment plan.
178.9 If the license holder cannot obtain the client's approval of the treatment plan, a mental health
178.10 professional must make efforts to obtain approval from a person who is authorized to consent
178.11 on the client's behalf within 30 days after the client's previous individual treatment plan
178.12 expired. A license holder may not deny a client service during this time period solely because
178.13 the license holder could not obtain the client's approval of the client's individual treatment
178.14 plan. A license holder may continue to bill for the client's otherwise eligible services when
178.15 the client re-engages in services.

178.16 (c) The individual treatment plan must be updated as necessary to reflect the changing
178.17 needs of the client. The individual treatment plan must provide assistance with accessing
178.18 necessary crisis services when the license holder is aware of the client's need for crisis
178.19 services. The license holder must review the client's individual treatment plan every 180
178.20 days and update the client's individual treatment plan with the client's treatment progress,
178.21 new treatment objectives and goals, or, if the client has not made treatment progress, changes
178.22 in the license holder's approach to treatment.

178.23 Sec. 31. **[245L.17] CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC**
178.24 **LICENSURE.**

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

178.27 (b) "Care coordination" means the activities required to coordinate care across settings
178.28 and providers for an individual served to ensure seamless transitions across the full spectrum
178.29 of health services. Care coordination includes:

178.30 (1) outreach and engagement;

178.31 (2) documenting a plan of care for medical, behavioral health, and social services and
178.32 supports in the integrated treatment plan;

178.33 (3) assisting with obtaining appointments;

179.1 (4) confirming appointments are kept;

179.2 (5) developing a crisis plan;

179.3 (6) tracking medication; and

179.4 (7) implementing care coordination agreements with external providers. Care coordination
179.5 may include psychiatric consultation with primary care practitioners and with mental health
179.6 clinical care practitioners.

179.7 (c) "CCBHC client" means an individual who has participated in a preliminary screening
179.8 and risk assessment and who has received at least one of the nine required services from a
179.9 CCBHC.

179.10 (d) "Certified community behavioral health clinic" or "CCBHC" means a provider of
179.11 integrated behavioral health services that is licensed under this section and compliant with
179.12 federal CCBHC requirements.

179.13 (e) "Community needs assessment" means an assessment to identify community needs
179.14 and determine the community behavioral health clinic's capacity to address the needs of the
179.15 population being served.

179.16 (f) "Designated collaborating organization" means an entity meeting the requirements
179.17 of subdivision 5 that has a formal agreement with a CCBHC to furnish CCBHC services.

179.18 (g) "Federal CCBHC criteria" means the most recently issued Certified Community
179.19 Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental
179.20 Health Services Administration.

179.21 (h) "Needs assessment" means the community needs assessment described in federal
179.22 criteria for CCBHC.

179.23 (i) "Preliminary screening and risk assessment" means a mandatory screening and risk
179.24 assessment that is completed at the time of first contact, whether that contact is in person,
179.25 by telephone, or using other remote communication.

179.26 Subd. 2. **Establishment of licensure.** (a) The certified community behavioral health
179.27 clinic model is an integrated service delivery model that uses evidence-based behavioral
179.28 health practices to achieve better outcomes for individuals experiencing behavioral health
179.29 concerns while achieving sustainable rates through cost-based reimbursement for providers
179.30 and economic efficiencies for payors.

179.31 (b) Beginning January 1, 2028, a CCBHC must be licensed under this section and chapter
179.32 245A.

180.1 (c) A CCBHC must meet the requirements of this section and federal CCBHC criteria.
180.2 The commissioner may require a CCBHC applicant or license holder to submit documentation
180.3 of compliance with state licensing requirements and federal CCBHC criteria. When permitted
180.4 by the Substance Abuse and Mental Health Services Administration, the commissioner may
180.5 select a transition date on which revisions to the federal CCBHC criteria become required
180.6 as licensing conditions for CCBHCs.

180.7 Subd. 3. **License extension.** (a) The commissioner must extend a compliant license
180.8 holder's license under this section for 36 months.

180.9 (b) The commissioner must complete a licensing review that includes an on-site inspection
180.10 within six months before the expiration of the CCBHC's current license.

180.11 (c) Within 180 days of license expiration, a CCBHC license holder must submit to the
180.12 commissioner all documentation required by the commissioner under subdivision 2,
180.13 paragraph (c).

180.14 Subd. 4. **Required services and scope of licensure.** Within a declared service area, the
180.15 CCBHC must be able to offer:

180.16 (1) mobile crisis services, directly or through a designated collaborating organization
180.17 under subdivision 4;

180.18 (2) outpatient mental health and substance use disorder treatment services under
180.19 subdivisions 9 and 10;

180.20 (3) screening, diagnosis, and risk assessment under subdivision 11;

180.21 (4) person- and family-centered treatment planning;

180.22 (5) psychiatric rehabilitation services under subdivision 14;

180.23 (6) community-based mental health care for veterans under subdivision 15;

180.24 (7) outpatient primary care screening and monitoring under subdivision 16;

180.25 (8) peer services under subdivision 17; and

180.26 (9) targeted case management under subdivision 18.

180.27 Subd. 5. **Designated collaborating organization.** (a) If a CCBHC is unable to provide
180.28 mobile crisis services, the CCBHC may contract with another entity that is licensed to
180.29 provide mobile crisis services under section 245I.24 and that meets the requirements of the
180.30 federal CCBHC criteria as a designated collaborating organization.

181.1 (b) The CCBHC must submit a designated collaborating organization arrangement for
181.2 approval to the commissioner as part of the licensing process.

181.3 Subd. 6. **Exemptions to host county approval.** Notwithstanding any other law that
181.4 requires a county contract or other form of county approval for a service listed in subdivision
181.5 4, a CCBHC that meets the requirements of this section may receive the prospective payment
181.6 under section 256B.0625, subdivision 5m, for that service without a county contract or
181.7 county approval.

181.8 Subd. 7. **Variances.** When the standards listed in this section or other applicable standards
181.9 conflict or address similar issues in duplicative or incompatible ways, the commissioner
181.10 may grant variances to state requirements if the variances do not conflict with federal
181.11 requirements for services reimbursed under medical assistance. If standards overlap, the
181.12 commissioner may substitute all or a part of a licensure or certification that is substantially
181.13 the same as another licensure or certification. The commissioner must consult with
181.14 stakeholders before granting variances under this provision. For a CCBHC that is licensed
181.15 but not approved for prospective payment under section 256B.0625, subdivision 5m, the
181.16 commissioner may grant a variance under this paragraph if the variance does not increase
181.17 the state share of costs.

181.18 Subd. 8. **Evidence-based practices.** The commissioner must issue a list of required
181.19 evidence-based practices to be delivered by CCBHCs and may also provide a list of
181.20 recommended evidence-based practices. The commissioner may update the list to reflect
181.21 advances in outcomes research and medical services for persons living with mental illnesses
181.22 or substance use disorders. When developing the list, the commissioner must consider the
181.23 adequacy of evidence to support the efficacy of the practice across cultures and ages, the
181.24 workforce available, and the current availability of the practices in the state. At least 30
181.25 days before issuing the initial list or issuing any revisions, the commissioner must provide
181.26 stakeholders with an opportunity to comment.

181.27 Subd. 9. **Outpatient mental health services.** (a) A license holder must provide outpatient
181.28 mental health services that comply with the federal CCBHC criteria and applicable state
181.29 standards in this chapter, except as provided in this subdivision.

181.30 (b) Completion of an initial or comprehensive evaluation fulfills the requirements to
181.31 perform a diagnostic assessment in accordance with section 245I.10, subdivisions 2 and 6.

181.32 (c) An integrated treatment plan under this section fulfills the requirements to conduct
181.33 treatment planning in accordance with section 245I.10, subdivisions 7 and 8.

182.1 (d) A license holder under this section is exempt from certification as a mental health
182.2 clinic under section 245I.20.

182.3 Subd. 10. **Outpatient substance use disorder treatment.** (a) When a license holder
182.4 provides substance use disorder treatment services to an individual with a substance use
182.5 disorder diagnosis, the license holder must comply with the requirements for substance use
182.6 disorder treatment services in chapter 245G, except as provided in this subdivision.

182.7 (b) Completion of a preliminary screening and risk assessment under this section fulfills
182.8 the requirements to complete an initial services plan under section 245G.04, subdivision 1.

182.9 (c) Completion of a comprehensive evaluation under this section fulfills the requirements
182.10 to administer a comprehensive assessment under section 245G.05.

182.11 (d) An integrated treatment plan under this section that contains a six-dimension analysis
182.12 of the client's needs according to the third edition of ASAM criteria, as defined in section
182.13 254B.01, subdivision 2a, fulfills the requirements to provide an individual treatment plan
182.14 under section 245G.06.

182.15 (e) A license holder under this section fulfills the requirement to document personnel
182.16 files under section 245G.13, subdivision 3, by complying with the requirements of this
182.17 chapter.

182.18 (f) A license holder under this section fulfills the requirement to protect client rights
182.19 under section 245G.15 by complying with the requirements of section 245I.12.

182.20 (g) A license holder under this section fulfills the requirements to respond to behavioral
182.21 emergencies under section 245G.16 by complying with the requirements of section 245I.03,
182.22 subdivision 4.

182.23 (h) A license holder under this section is exempt from licensure under chapter 245G.

182.24 Subd. 11. **Initial triage and risk assessment.** (a) A license holder must have policies
182.25 and procedures on:

182.26 (1) how staff will implement the requirements of this subdivision;

182.27 (2) staff positions authorized to complete triage and risk assessments;

182.28 (3) documenting the results of the risk screenings; and

182.29 (4) ensuring the client is offered timely services according to the federal CCBHC criteria.

182.30 (b) A license holder must conduct an initial triage and risk assessment when a new client
182.31 requests services or is referred to services. A license holder may conduct an initial triage

183.1 and risk assessment in person, by telephone, or through other remote communication. Based
183.2 on the acuity of needs as assessed in the initial triage and risk assessment, the client must
183.3 be categorized as having emergency, urgent, or routine needs.

183.4 (c) Based on these categorizations, the license holder must offer services that meet the
183.5 relevant timelines under the federal CCBHC criteria.

183.6 (d) The license holder must provide training that addresses:

183.7 (1) when a prospective client requires intervention from qualified staff;

183.8 (2) the use of standardized measures that screen for significant risks;

183.9 (3) other factors that indicate a client has urgent needs besides the Columbia Suicide

183.10 Severity Rating Scale or a self-harm screening; and

183.11 (4) overdose and substance use disorder risks.

183.12 Subd. 12. **Initial and comprehensive evaluation.** (a) A license holder under this section
183.13 must provide initial and comprehensive evaluations according to this section and federal
183.14 CCBHC criteria.

183.15 (b) An initial evaluation is necessary to authorize the provision of all medically necessary
183.16 CCBHC services until the completion of a comprehensive evaluation. A comprehensive
183.17 evaluation is necessary to authorize the provision of all medically necessary CCBHC services
183.18 on an ongoing basis. A license holder must ensure that each client's comprehensive evaluation
183.19 reflects the needs and assessments for all services provided.

183.20 Subd. 13. **Integrated treatment plan.** (a) A license holder under this section must
183.21 complete an integrated treatment plan for each client following the client's comprehensive
183.22 evaluation no later than 60 calendar days after the date of the first request for services.

183.23 (b) A license holder must document all required services under subdivision 9 within the
183.24 integrated treatment plan based on the client's needs.

183.25 (c) A license holder must review and update a client's integrated treatment plan as
183.26 necessary to reflect the changing needs of the client and progress made in treatment. If the
183.27 client has not made treatment progress, updates to the treatment plan must indicate changes
183.28 in the license holder's approach to treatment to better meet the needs of the client. A license
183.29 holder must review and update the integrated treatment plan at least every 180 days or as
183.30 clinically indicated.

183.31 Subd. 14. **Psychiatric rehabilitation services.** (a) For children, a license holder under
183.32 this section must provide children's therapeutic services and supports according to sections

184.1 245I.30 and 245I.31, except that an initial or comprehensive assessment under this section
184.2 fulfills the requirement to perform a standard diagnostic assessment.

184.3 (b) For adults, a license holder under this section must provide adult rehabilitative mental
184.4 health services according to section 245I.22, except that:

184.5 (1) the license holder is exempt from the requirement to perform a level of care
184.6 assessment under section 245I.22, subdivision 6, paragraph (b); and

184.7 (2) an initial or comprehensive assessment under this section fulfills the requirement to
184.8 perform a standard diagnostic assessment.

184.9 Subd. 15. **Community-based care for veterans.** (a) The license holder must provide
184.10 services according to federal requirements for eligibility and coordination with TRICARE
184.11 and the United States Department of Veterans Affairs.

184.12 (b) The license holder must assign and document a principal behavioral health provider
184.13 for every veteran receiving services.

184.14 Subd. 16. **Primary care screening and monitoring.** To fulfill the requirements for
184.15 primary care screening, a license holder under this section must have policies and procedures
184.16 detailing the screenings to be performed with specific populations at the clinic. The policies
184.17 and procedures must be approved by the medical director.

184.18 Subd. 17. **Peer services.** A license holder must be able to provide peer services as
184.19 described by federal CCBHC criteria and sections 245G.07, subdivision 2, clause (8),
184.20 256B.0615, and 256B.0616.

184.21 Subd. 18. **Targeted case management.** (a) A license holder must provide mental health
184.22 targeted case management as described by federal CCBHC criteria and section 256B.0625,
184.23 subdivision 20.

184.24 (b) An initial or comprehensive evaluation under this section fulfills any requirement
184.25 to perform a standard diagnostic assessment for targeted case management.

184.26 Subd. 19. **Community needs assessment.** (a) The community needs assessment must
184.27 be a collaborative document that reflects the license holder's or applicant's engagement with
184.28 current clients, other social and medical services agencies, community groups, underserved
184.29 populations, and government agencies. The applicant or license holder must document an
184.30 outreach plan within the community needs assessment to demonstrate how stakeholder
184.31 feedback was solicited and reflected in the plan.

185.1 (b) The applicant or license holder must publicly post a draft community needs assessment
185.2 on the organization's website for 30 days and submit a summary of public comments and
185.3 recommendations from the comment period to the commissioner.

185.4 (c) In the draft community needs assessment, the applicant or license holder must declare
185.5 a planned geographic service delivery area in which the CCBHC will be capable of providing
185.6 all nine required services. An applicant must provide an analysis of how CCBHC status
185.7 will lead to a significant improvement in the availability and quality of the services. An
185.8 existing license holder must include analysis of which needs from prior needs assessments
185.9 have been improved by the operation of the CCBHC. A clinic that has not made and
185.10 demonstrated substantial progress in addressing the identified needs must specify what
185.11 changes will occur to address the lack of progress.

185.12 (d) The commissioner must provide feedback and technical assistance if the community
185.13 needs assessment must be revised.

185.14 Subd. 20. **Staffing plan.** Based on an accepted community needs assessment, the
185.15 applicant or license holder must complete a staffing plan. The staffing plan must include
185.16 analysis of the extent to which identified staffing levels will be capable of meeting the needs
185.17 identified in the community needs assessment.

185.18 Subd. 21. **Data and evaluation.** A provider must submit documentation that establishes
185.19 the ability of the clinic to complete the required data collection as a CCBHC, as determined
185.20 by the commissioner. For an applicant that is an existing provider, the commissioner must
185.21 review and evaluate data submitted related to claims, grants, and other reporting to ensure
185.22 the data meets reporting requirements.

185.23 Subd. 22. **Cost reporting.** A provider must submit a cost report on the forms and in the
185.24 manner required in section 256B.0625, subdivision 5m.

185.25 Sec. 32. **[245I.22] ADULT REHABILITATIVE MENTAL HEALTH SERVICES.**

185.26 Subdivision 1. **Generally.** Beginning January 1, 2028, a provider of adult mental health
185.27 rehabilitative services must be licensed under this section and chapter 245A.

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

185.30 (b) "Adult mental health rehabilitative services" or "ARMHS" has the meaning given
185.31 in section 245I.02, subdivision 33.

186.1 (c) "Basic living skills" means rehabilitative interventions that instruct, assist, and support
186.2 the client with:

186.3 (1) interpersonal communication skills;

186.4 (2) community resource utilization and integration skills;

186.5 (3) crisis planning;

186.6 (4) relapse prevention skills;

186.7 (5) health care directives;

186.8 (6) budgeting and shopping skills;

186.9 (7) healthy lifestyle skills and practices;

186.10 (8) cooking and nutrition skills;

186.11 (9) transportation skills;

186.12 (10) mental illness symptom management skills;

186.13 (11) household management skills;

186.14 (12) employment-related skills; and

186.15 (13) parenting skills.

186.16 (d) "Community intervention" means a client's community assisting in the client's
186.17 rehabilitation, including consultation with relatives, guardians, friends, employers, treatment
186.18 providers, and other significant individuals. Community intervention is appropriate when
186.19 directed exclusively to the treatment of the client.

186.20 (e) "Medication education services" means services provided individually or in groups
186.21 that focus on educating the client about mental illness and symptoms, the role and effects
186.22 of medications in treating symptoms of mental illness, and the side effects of medications.
186.23 Medication education services must be coordinated with, but must not duplicate, medication
186.24 management services. Medication education services must be provided by physicians,
186.25 advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

186.26 (f) "Transition to community living services" means services that maintain continuity
186.27 of contact between the ARMHS provider and the client and facilitate discharge from a
186.28 hospital, residential treatment program, board and lodging facility, or nursing home.
186.29 Transition to community living services must not be used to provide other areas of adult
186.30 rehabilitative mental health services.

187.1 Subd. 3. **Service components.** An ARMHS provider must be capable of providing:

187.2 (1) basic living skills;

187.3 (2) medication education services;

187.4 (3) community intervention; and

187.5 (4) transition to community living services.

187.6 Subd. 4. **Provider requirements.** An ARMHS license holder must be enrolled with

187.7 medical assistance and comply with standards in section 256B.0623.

187.8 Subd. 5. **Qualifications.** ARMHS must be provided by:

187.9 (1) a mental health professional qualified under section 245I.04, subdivision 2;

187.10 (2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

187.11 (3) a clinical trainee qualified under section 245I.04, subdivision 6;

187.12 (4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

187.13 (5) a mental health certified peer specialist qualified under section 245I.04, subdivision

187.14 12; or

187.15 (6) a mental health rehabilitation worker qualified under section 245I.04, subdivision

187.16 14.

187.17 Subd. 6. **Service planning.** (a) An ARMHS provider must complete a written functional

187.18 assessment according to section 245I.10, subdivision 9, for each client.

187.19 (b) When an ARMHS provider completes a written functional assessment, the provider

187.20 must also complete a level of care assessment, as defined in section 245I.02, subdivision

187.21 19, for the client.

187.22 Subd. 7. **Group modality.** ARMHS may be provided in group settings if appropriate

187.23 to each participating client's needs and treatment plan. A group is defined as two to ten

187.24 clients, at least one of whom is concurrently receiving ARMHS. The service and group

187.25 must be specified in the client's individual treatment plan.

187.26 Sec. 33. Minnesota Statutes 2024, section 245I.23, subdivision 4, is amended to read:

187.27 **Subd. 4. Required intensive residential treatment services.** (a) On a daily basis, the

187.28 license holder must follow a client's treatment plan to provide intensive residential treatment

187.29 services to the client to improve the client's functioning.

188.1 (b) The license holder must offer and have the capacity to directly provide the following
188.2 treatment services to each client:

188.3 (1) daily rehabilitative mental health services;

188.4 (2) crisis prevention planning to assist a client with:

188.5 (i) identifying and addressing patterns in the client's history and experience of the client's
188.6 mental illness; and

188.7 (ii) developing crisis prevention strategies that include de-escalation strategies that have
188.8 been effective for the client in the past;

188.9 (3) health services and administering medication;

188.10 (4) co-occurring substance use disorder treatment;

188.11 (5) engaging the client's family and other natural supports in the client's treatment and
188.12 educating the client's family and other natural supports to strengthen the client's social and
188.13 family relationships; and

188.14 (6) making referrals for the client to other service providers in the community and
188.15 supporting the client's transition from intensive residential treatment services to another
188.16 setting.

188.17 (c) The license holder must include Illness Management and Recovery (IMR), Enhanced
188.18 Illness Management and Recovery (E-IMR), or other similar interventions in the license
188.19 holder's programming as approved by the commissioner.

188.20 Sec. 34. Minnesota Statutes 2024, section 245I.23, subdivision 5, is amended to read:

188.21 Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the
188.22 license holder must follow a client's individual crisis treatment plan to provide services to
188.23 the client in residential crisis stabilization to improve the client's functioning.

188.24 (b) The license holder must offer and have the capacity to directly provide the following
188.25 treatment services to the client:

188.26 (1) daily crisis stabilization services as described in section 256B.0624, subdivision 7;

188.27 (2) rehabilitative mental health services;

188.28 (3) health services and administering the client's medications; and

188.29 (4) making referrals for the client to other service providers in the community and
188.30 supporting the client's transition from residential crisis stabilization to another setting.

189.1 Sec. 35. Minnesota Statutes 2025 Supplement, section 245I.23, subdivision 7, is amended
189.2 to read:

189.3 Subd. 7. **Intensive residential treatment services assessment and treatment**
189.4 **planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and
189.5 document the client's immediate needs, including the client's:

189.6 (1) health and safety, including the client's need for crisis assistance;

189.7 (2) responsibilities for children, family and other natural supports, and employers; and

189.8 (3) housing and legal issues.

189.9 (b) Within 24 hours of the client's admission, the license holder must complete an initial
189.10 treatment plan for the client. The license holder must:

189.11 (1) base the client's initial treatment plan on the client's referral information and an
189.12 assessment of the client's immediate needs;

189.13 (2) consider crisis assistance strategies that have been effective for the client in the past;

189.14 (3) identify the client's initial treatment goals, measurable treatment objectives, and
189.15 specific interventions, and the frequency of interventions, that the license holder will use
189.16 to help the client engage in treatment;

189.17 (4) identify the participants involved in the client's treatment planning. The client must
189.18 be a participant; and

189.19 (5) ensure that a treatment supervisor approves of the client's initial treatment plan if a
189.20 behavioral health practitioner or clinical trainee completes the client's treatment plan,
189.21 notwithstanding section 245I.08, subdivision 3.

189.22 (c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must
189.23 complete an individual abuse prevention plan as part of a client's initial treatment plan.

189.24 (d) Within five days of the client's admission and again within 60 days after the client's
189.25 admission, the license holder must complete a level of care assessment of the client. If the
189.26 license holder determines that a client does not need a medically monitored level of service,
189.27 a treatment supervisor must document how the client's admission to and continued services
189.28 in intensive residential treatment services are medically necessary for the client.

189.29 (e) Within ten days of a client's admission, the license holder must complete or review
189.30 and update the client's standard diagnostic assessment.

190.1 (f) Within ten days of a client's admission, the license holder must complete the client's
190.2 individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days
190.3 after the client's admission and again within 70 days after the client's admission, the license
190.4 holder must update the client's individual treatment plan. The license holder must focus the
190.5 client's treatment planning on preparing the client for a successful transition from intensive
190.6 residential treatment services to another setting. The individual treatment plan must be based
190.7 on the client's diagnostic assessment and functional assessment and must contain, at a
190.8 minimum, identified goals according to subdivision 4, paragraph (b), clauses (1) to (3), or
190.9 subdivision 5, paragraph (b), clause (1), as applicable. In addition to the required elements
190.10 of an individual treatment plan under section 245I.10, subdivision 8, the license holder must
190.11 identify the following information in the client's individual treatment plan: (1) the client's
190.12 referrals and resources for the client's health and safety; and (2) the staff persons who are
190.13 responsible for following up with the client's referrals and resources. If the client does not
190.14 receive a referral or resource that the client needs, the license holder must document the
190.15 reason that the license holder did not make the referral or did not connect the client to a
190.16 particular resource. The license holder is responsible for determining whether additional
190.17 follow-up is required on behalf of the client.

190.18 (g) Within 30 days of the client's admission, the license holder must complete a functional
190.19 assessment of the client. Within 60 days after the client's admission, the license holder must
190.20 update the client's functional assessment to include any changes in the client's functioning
190.21 and symptoms.

190.22 (h) For a client with a current substance use disorder diagnosis and for a client whose
190.23 substance use disorder screening in the client's standard diagnostic assessment indicates the
190.24 possibility that the client has a substance use disorder, the license holder must complete a
190.25 written assessment of the client's substance use within 30 days of the client's admission. In
190.26 the substance use assessment, the license holder must: (1) evaluate the client's history of
190.27 substance use, relapses, and hospitalizations related to substance use; (2) assess the effects
190.28 of the client's substance use on the client's relationships including with family member and
190.29 others; (3) identify financial problems, health issues, housing instability, and unemployment;
190.30 (4) assess the client's legal problems, past and pending incarceration, violence, and
190.31 victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking
190.32 prescribed medications, and noncompliance with psychosocial treatment.

190.33 (i) On a weekly basis, a mental health professional or certified rehabilitation specialist
190.34 must review each client's treatment plan and individual abuse prevention plan. The license
190.35 holder must document in the client's file each weekly review of the client's treatment plan

191.1 and individual abuse prevention plan. An individual treatment plan must be updated based
191.2 on new information gathered about the client's conditions, the client's level of participation,
191.3 and whether identified interventions have had the intended effect.

191.4 Sec. 36. Minnesota Statutes 2025 Supplement, section 245I.23, subdivision 10, is amended
191.5 to read:

191.6 Subd. 10. **Minimum treatment team staffing levels and ratios.** (a) The license holder
191.7 must maintain a treatment team staffing level sufficient to:

191.8 (1) provide continuous daily coverage of all shifts;

191.9 (2) follow each client's treatment plan and meet each client's needs as identified in the
191.10 client's treatment plan;

191.11 (3) implement program requirements; and

191.12 (4) safely monitor and guide the activities of each client, taking into account the client's
191.13 level of behavioral and psychiatric stability, cultural needs, and vulnerabilities.

191.14 (b) The license holder must ensure that treatment team members:

191.15 (1) remain awake during all work hours; and

191.16 (2) are available to monitor and guide the activities of each client whenever clients are
191.17 present in the program.

191.18 (c) On each shift, the license holder must maintain a treatment team staffing ratio of at
191.19 least one treatment team member to nine clients. If the license holder is serving nine or
191.20 fewer clients, at least one treatment team member on the day shift must be a mental health
191.21 professional, clinical trainee, certified rehabilitation specialist, or behavioral health
191.22 practitioner. If the license holder is serving more than nine clients, at least one of the
191.23 treatment team members working during both the day and evening shifts must be a mental
191.24 health professional, clinical trainee, certified rehabilitation specialist, or behavioral health
191.25 practitioner.

191.26 (d) If the license holder provides residential crisis stabilization to clients and is serving
191.27 at least one client in residential crisis stabilization and more than four clients in residential
191.28 crisis stabilization and intensive residential treatment services, the license holder must
191.29 maintain a treatment team staffing ratio on each shift of at least two treatment team members
191.30 during the client's first 48 hours in residential crisis stabilization.

192.1 (e) The license holder must maintain documentation of a daily staffing schedule indicating
192.2 the names and credentials of individuals providing services, according to the record retention
192.3 requirements under section 245A.041.

192.4 Sec. 37. Minnesota Statutes 2024, section 245I.23, subdivision 12, is amended to read:

192.5 Subd. 12. **Daily documentation.** (a) For each day that a client is present in the program,
192.6 the license holder must provide a daily summary in the client's file that includes observations
192.7 about the client's behavior and symptoms, including any critical incidents in which the client
192.8 was involved, and documentation of a daily medically necessary rehabilitation service
192.9 according to section 245I.08.

192.10 (b) For each day that a client is not present in the program, the license holder must
192.11 document the reason for a client's absence in the client's file.

192.12 Sec. 38. Minnesota Statutes 2024, section 245I.23, subdivision 17, is amended to read:

192.13 Subd. 17. **Admissions referrals and determinations.** (a) The license holder must
192.14 identify the information that the license holder needs to make a determination about a
192.15 person's admission referral.

192.16 (b) The license holder must:

192.17 (1) always be available to receive referral information about a person seeking admission
192.18 to the license holder's program;

192.19 (2) respond to the referral source within eight hours of receiving a referral and, within
192.20 eight hours, communicate with the referral source about what information the license holder
192.21 needs to make a determination concerning the person's admission;

192.22 (3) consider the license holder's staffing ratio and the areas of treatment team members'
192.23 competency when determining whether the license holder is able to meet the needs of a
192.24 person seeking admission; ~~and~~

192.25 (4) determine whether to admit a person within 72 hours of receiving all necessary
192.26 information from the referral source; and

192.27 (5) document client eligibility according to subdivision 15, paragraph (a), and subdivision
192.28 16.

193.1 Sec. 39. [245I.24] MOBILE CRISIS RESPONSE SERVICES.

193.2 Subdivision 1. Generally. (a) Mobile crisis response services provide short-term,
193.3 face-to-face mental health care in community settings for adults and children experiencing
193.4 crisis to help individuals maintain safety and return to a baseline level of functioning.

193.5 (b) Beginning January 1, 2028, a provider of mobile crisis response services must be
193.6 licensed under this section and chapter 245A.

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

193.9 (b) "Crisis assessment" means an immediate face-to-face assessment by a physician, a
193.10 mental health professional, or a qualified member of a crisis team, as described in subdivision
193.11 5.

193.12 (c) "Crisis intervention" means face-to-face, short-term intensive mental health services
193.13 initiated during a mental health crisis to help an individual cope with immediate stressors,
193.14 identify and utilize available resources and strengths, engage in voluntary treatment, and
193.15 begin to return to the individual's baseline level of functioning.

193.16 (d) "Crisis screening" means a screening of a client's potential mental health crisis
193.17 situation under subdivision 6.

193.18 (e) "Crisis stabilization services" means individualized mental health services that are
193.19 designed to restore an individual to the individual's baseline level of functioning. Crisis
193.20 stabilization services may be provided in the individual's home, the home of a family member
193.21 or friend of the individual, another community setting, a short-term supervised licensed
193.22 residential program, or an emergency department. Crisis stabilization services include family
193.23 psychoeducation.

193.24 (f) "Crisis team" means the staff of a provider entity who are supervised and prepared
193.25 to provide mobile crisis services to a client in a potential mental health crisis situation.

193.26 (g) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without
193.27 the provision of crisis response services, would likely result in significantly reducing the
193.28 individual's levels of functioning in primary activities of daily living, the individual needing
193.29 emergency services under section 62Q.55, or the individual being placed in a more restrictive
193.30 setting, including but not limited to inpatient hospitalization.

193.31 (h) "Mobile crisis services" means screening, assessment, intervention, and
193.32 community-based crisis stabilization services that are provided to an individual client.
193.33 Mobile crisis services does not include residential crisis stabilization.

194.1 Subd. 3. **Eligibility.** (a) An individual is eligible for crisis assessment services when the
194.2 person has screened positive for a potential mental health crisis during a crisis screening.

194.3 (b) An individual is eligible for crisis intervention services and crisis stabilization services
194.4 when the individual has been assessed during a crisis assessment to be experiencing a mental
194.5 health crisis.

194.6 Subd. 4. **Policies, procedures, and practices specified.** (a) In addition to the policies
194.7 and procedures required by section 245I.03, the license holder must establish, enforce, and
194.8 maintain policies and procedures to:

194.9 (1) ensure that crisis screenings, crisis assessments, and crisis intervention services are
194.10 available 24 hours per day, seven days per week;

194.11 (2) respond to a call for services in a designated service area or according to a written
194.12 agreement with the local mental health authority for an adjacent area;

194.13 (3) have at least one mental health professional on staff at all times and at least one
194.14 additional staff member capable of leading a crisis response in the community; and

194.15 (4) respond to clients in the community according to the requirements and priorities in
194.16 subdivision 6.

194.17 (b) The license holder must provide the commissioner with information about the number
194.18 of requests for service, the number of clients that the provider serves face-to-face, and client
194.19 outcomes at least every six months, in a form and manner prescribed by the commissioner.

194.20 (c) The license holder must:

194.21 (1) provide support for an individual's family and natural supports by enabling the
194.22 individual's family and natural supports to observe and participate in the individual's
194.23 treatment, assessments, and planning services;

194.24 (2) implement culturally specific treatment identified in the crisis treatment plan that is
194.25 meaningful and appropriate, as determined by the individual's culture, beliefs, values, and
194.26 language;

194.27 (3) respond to an individual's changing intervention and care needs, as identified by the
194.28 individual or a family member; and

194.29 (4) have the communication tools and procedures to communicate and consult promptly
194.30 about crisis assessment and interventions as services are provided.

194.31 (d) The license holder must coordinate services with:

195.1 (1) county emergency services under section 245.469, community hospitals, ambulance
195.2 services, transportation services, social services, law enforcement, engagement services,
195.3 and mental health crisis services through regularly scheduled interagency meetings;

195.4 (2) other behavioral health service providers, county mental health authorities, or federally
195.5 recognized American Indian authorities, and others as necessary, with the consent of the
195.6 individual or parent or guardian;

195.7 (3) detoxification, withdrawal management services, and medical stabilization services
195.8 as needed; and

195.9 (4) the individual's case manager if the individual is receiving case management services.

195.10 Subd. 5. Crisis assessment and intervention staff qualifications. (a) Crisis assessment
195.11 and intervention services must be provided by:

195.12 (1) a mental health professional qualified under section 245I.04, subdivision 2;

195.13 (2) a clinical trainee qualified under section 245I.04, subdivision 6;

195.14 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

195.15 (4) a mental health certified family peer specialist qualified under section 245I.04,
195.16 subdivision 12; or

195.17 (5) a mental health certified peer specialist qualified under section 245I.04, subdivision
195.18 10.

195.19 (b) When crisis assessment and intervention services are provided to an individual in
195.20 the community, a mental health professional, clinical trainee, or mental health practitioner
195.21 must lead the response.

195.22 (c) For providers under this section, the 30 hours of ongoing training required by section
195.23 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children
195.24 and adults and include training about evidence-based practices identified by the commissioner
195.25 of health to reduce the individual's risk of suicide and self-injurious behavior.

195.26 (d) At least six hours of the ongoing training under paragraph (c) must be specific to
195.27 working with families and providing crisis stabilization services to children and include the
195.28 following topics:

195.29 (1) developmental tasks of childhood and adolescence;

195.30 (2) family relationships;

195.31 (3) child and youth engagement and motivation, including motivational interviewing;

196.1 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
196.2 queer youth;

196.3 (5) positive behavior support;

196.4 (6) crisis intervention for youth with developmental disabilities;

196.5 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
196.6 therapy; and

196.7 (8) youth substance use.

196.8 (e) Individual providers must be experienced in crisis assessment, crisis intervention
196.9 techniques, treatment engagement strategies, working with families, and clinical decision
196.10 making under emergency conditions and have knowledge of local services and resources.

196.11 Subd. 6. Crisis screening. (a) A license holder may use the resources of emergency
196.12 services under section 245.469 for crisis screening. The crisis screening must gather
196.13 information, determine whether a mental health crisis situation exists, identify parties
196.14 involved, and determine an appropriate response.

196.15 (b) When conducting a crisis screening, a provider must:

196.16 (1) employ evidence-based practices to reduce the individual's risk of suicide and
196.17 self-injurious behavior;

196.18 (2) work with the individual to establish a plan and time frame for responding to the
196.19 individual's mental health crisis, including responding to the individual's immediate need
196.20 for support by telephone or text message until the provider can respond to the individual
196.21 face-to-face;

196.22 (3) document significant factors in determining whether the individual is experiencing
196.23 a mental health crisis, including prior requests for crisis services, an individual's recent
196.24 presentation at an emergency department, known calls to 911 or law enforcement, or
196.25 information from third parties with knowledge of an individual's history or current needs;

196.26 (4) accept calls from interested third parties and consider the additional needs or potential
196.27 mental health crises that the third parties may be experiencing;

196.28 (5) provide psychoeducation, including reducing access to means of suicide, to relevant
196.29 third parties including family members or other persons living with the individual; and

196.30 (6) consider other available services to determine which service intervention would best
196.31 address the individual's needs and circumstances.

197.1 (c) For the purposes of this section, the following situations indicate a positive screen
197.2 for a potential mental health crisis:

197.3 (1) the individual presents at an emergency department or urgent care setting and the
197.4 health care team at that location requested crisis services; or

197.5 (2) a peace officer requested crisis services for an individual who is potentially subject
197.6 to transportation under section 253B.051.

197.7 (d) The provider must prioritize providing a face-to-face crisis assessment of the
197.8 individual, unless a provider documents specific evidence to show why the face-to-face
197.9 assessment was not possible, including insufficient staffing resources, concerns for staff or
197.10 individual safety, or other clinical factors.

197.11 (e) A provider is not required to have direct contact with the individual to determine
197.12 that the individual is experiencing a potential mental health crisis. A mobile crisis provider
197.13 may gather relevant information about the individual from a third party to establish the
197.14 individual's need for services and potential safety factors.

197.15 Subd. 7. **Crisis assessment.** (a) If an individual screens positive for a potential mental
197.16 health crisis, a crisis assessment must be completed. A crisis assessment must evaluate any
197.17 immediate needs for which services are needed and, as time permits, the individual's:

197.18 (1) current life situation;

197.19 (2) health information, including current medications;

197.20 (3) sources of stress;

197.21 (4) mental health problems and symptoms;

197.22 (5) strengths;

197.23 (6) cultural considerations;

197.24 (7) support network;

197.25 (8) vulnerabilities;

197.26 (9) current functioning; and

197.27 (10) preferences, as communicated directly by the individual or as communicated in a
197.28 health care directive as described in chapters 145C and 253B, the crisis treatment plan
197.29 described in subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

197.30 (b) A provider must conduct a crisis assessment at the individual's location when
197.31 appropriate and, when not appropriate, document the reasons.

198.1 (c) Whenever possible, the assessor must attempt to include input from the individual,
198.2 the individual's family, and other natural supports to assess whether a crisis exists.

198.3 (d) A crisis assessment must include a determination of:

198.4 (1) whether the individual is willing to voluntarily engage in treatment;

198.5 (2) whether the individual has an advance directive; and

198.6 (3) gathering the individual's information and history from involved family or other
198.7 natural supports.

198.8 (e) If a team determines that the individual does not need an acute level of care, the team
198.9 must provide services or service coordination if the individual has a co-occurring substance
198.10 use disorder and is otherwise eligible for services.

198.11 (f) If, after completing a crisis assessment, a provider refers the individual to an intensive
198.12 setting, including an emergency department, inpatient hospitalization, or residential crisis
198.13 stabilization, one of the crisis team members who completed or conferred about the
198.14 individual's crisis assessment must immediately contact the referral entity and consult with
198.15 the staff responsible for triage or intake at the referral entity. During the consultation, the
198.16 crisis team member must convey key findings or concerns that led to the individual's referral.
198.17 Following the consultation, the provider must also send written documentation to the referral
198.18 entity. The provider must document if the individual or the individual's legal guardian signed
198.19 releases for health records or if an exception under section 144.293, subdivision 5, exists.

198.20 Subd. 8. **Crisis intervention services.** (a) If the crisis assessment determines an individual
198.21 needs mobile crisis intervention services, the license holder must provide crisis intervention
198.22 services promptly. As able during the intervention, at least two members of the mobile crisis
198.23 intervention team must confer directly or by telephone about the crisis assessment, crisis
198.24 treatment plan, and actions taken and needed. At least one of the team members must be
198.25 providing face-to-face crisis intervention services. If providing crisis intervention services,
198.26 a clinical trainee or mental health practitioner must seek treatment supervision as required
198.27 in subdivision 10.

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

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

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

199.1 (e) If the individual's mental health crisis is stabilized, but the individual needs a referral
199.2 to other services, the team must provide referrals to these services. If the individual is unable
199.3 to follow up on the referral, the team must link the individual to the service and follow up
199.4 to ensure the individual is receiving the service.

199.5 Subd. 9. Crisis stabilization services. (a) Crisis stabilization services must be provided
199.6 by qualified staff of a crisis stabilization services provider entity, which must:

199.7 (1) develop a crisis treatment plan that meets the criteria in subdivision 11;

199.8 (2) complete a vulnerable adult determination in accordance with section 245A.65,
199.9 subdivision 1a;

199.10 (3) deliver crisis stabilization services according to the crisis treatment plan and include
199.11 face-to-face contact with the individual receiving services by qualified staff for further
199.12 assessment, help with referrals, updating of the crisis treatment plan, skills training, and
199.13 collaboration with other service providers in the community;

199.14 (4) if the provider delivers crisis stabilization services while the individual is absent,
199.15 document the reason for delivering services while the individual is absent; and

199.16 (5) if the individual's mental health crisis is stabilized and the individual does not have
199.17 a health care directive or psychiatric declaration, as defined in chapter 145C or section
199.18 253B.03, subdivision 6d, offer to work with the individual to develop a directive or
199.19 declaration.

199.20 (b) A staff member providing crisis stabilization services must be:

199.21 (1) a mental health professional qualified under section 245I.04, subdivision 2;

199.22 (2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

199.23 (3) a clinical trainee qualified under section 245I.04, subdivision 6;

199.24 (4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

199.25 (5) a mental health certified family peer specialist qualified under section 245I.04,
199.26 subdivision 12;

199.27 (6) a mental health certified peer specialist qualified under section 245I.04, subdivision
199.28 10; or

199.29 (7) a mental health rehabilitation worker qualified under section 245I.04, subdivision
199.30 14.

200.1 (c) For providers under this section, the 30 hours of ongoing training required in section
200.2 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children
200.3 and adults and include training about evidence-based practices identified by the commissioner
200.4 of health to reduce an individual's risk of suicide and self-injurious behavior.

200.5 (d) For providers who deliver care to children 21 years of age or younger, at least six
200.6 hours of the ongoing training under this subdivision must be specific to working with families
200.7 and providing crisis stabilization services to children, including the following topics:

200.8 (1) developmental tasks of childhood and adolescence;

200.9 (2) family relationships;

200.10 (3) child and youth engagement and motivation, including motivational interviewing;

200.11 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
200.12 queer youth;

200.13 (5) positive behavior support;

200.14 (6) crisis intervention for youth with developmental disabilities;

200.15 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
200.16 therapy; and

200.17 (8) youth substance use.

200.18 This paragraph does not apply to adult residential crisis stabilization services providers
200.19 licensed under section 245I.23 or providing services pursuant to section 256B.0624,
200.20 subdivision 7a.

200.21 Subd. 10. **Supervision.** Clinical trainees and mental health practitioners may provide
200.22 crisis assessment and crisis intervention services if the following treatment supervision
200.23 requirements are met:

200.24 (1) the license holder must accept full responsibility for the services provided;

200.25 (2) a mental health professional working for the license holder must be immediately
200.26 available by telephone or in person for treatment supervision;

200.27 (3) a mental health professional must be consulted, in person or by telephone, during
200.28 the first three hours when a clinical trainee or mental health practitioner provides crisis
200.29 assessment or crisis intervention services; and

200.30 (4) a mental health professional must:

201.1 (i) review and approve, as defined in section 245I.02, subdivision 2, the tentative crisis
201.2 assessment and crisis treatment plan within 24 hours of first providing services to the
201.3 individual, notwithstanding section 245I.08, subdivision 3; and

201.4 (ii) document the consultation required in clause (3).

201.5 Subd. 11. **Crisis treatment plan.** (a) Within 24 hours of an individual's admission, the
201.6 license holder must complete the individual's crisis treatment plan. The license holder must:

201.7 (1) base the individual's crisis treatment plan on the individual's crisis assessment;

201.8 (2) consider crisis assistance strategies that have been effective for the individual in the
201.9 past;

201.10 (3) for a child, use a child-centered, family-driven, and culturally appropriate planning
201.11 process that allows the child's parents and guardians to observe or participate in the child's
201.12 individual and family treatment services, assessment, and treatment planning;

201.13 (4) for an adult, use a person-centered, culturally appropriate planning process that allows
201.14 the individual's family and other natural supports to observe or participate in treatment
201.15 services, assessment, and treatment planning;

201.16 (5) identify the participants involved in the individual's treatment planning. The individual
201.17 must be a participant if possible;

201.18 (6) identify the individual's initial treatment goals, measurable treatment objectives, and
201.19 specific interventions that the license holder will use to help the person engage in treatment;

201.20 (7) include documentation of referral to and scheduling of services, including specific
201.21 providers where applicable;

201.22 (8) ensure that the individual or the individual's legal guardian approves under section
201.23 245I.02, subdivision 2, of the individual's crisis treatment plan unless a court orders the
201.24 individual's treatment plan under chapter 253B. If the individual or the individual's legal
201.25 guardian disagrees with the crisis treatment plan, the license holder must document in the
201.26 client file the reasons why the individual disagrees with the crisis treatment plan; and

201.27 (9) ensure that a treatment supervisor approves, as defined in section 245I.02, subdivision
201.28 2, of the individual's treatment plan within 24 hours of the individual's admission if a mental
201.29 health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding
201.30 section 245I.08, subdivision 3.

201.31 (b) The provider entity must provide the individual and the individual's legal guardian
201.32 with a copy of the crisis treatment plan.

202.1 Subd. 12. **Application requirements.** In a licensing application submitted under this
202.2 section and section 245A.04, the applicant must demonstrate that the applicant is:

202.3 (1) enrolled as a medical assistance provider; and

202.4 (2) in compliance with the provider type requirements under section 256B.0624,
202.5 subdivision 4, as determined by the commissioner.

202.6 Sec. 40. **[245I.30] CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

202.7 Subdivision 1. **Generally.** (a) "Children's therapeutic services and supports" means a
202.8 flexible package of community-based mental health services for children who require varying
202.9 therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness.

202.10 Interventions are delivered using various treatment modalities and combinations of services
202.11 designed to reach treatment outcomes identified in the individual treatment plan. Children's
202.12 therapeutic services and supports include development and rehabilitative services that
202.13 support a child's developmental treatment needs.

202.14 (b) Beginning January 1, 2028, a provider of children's therapeutic services and supports
202.15 must be licensed under this section and chapter 245A.

202.16 Subd. 2. **Service components.** (a) A children's therapeutic services and supports license
202.17 holder must be capable of providing:

202.18 (1) individual and family psychotherapy, psychotherapy for crises, and group
202.19 psychotherapy;

202.20 (2) individual, family, or group skills training; and

202.21 (3) crisis planning.

202.22 (b) Crisis planning that meets the standards in section 245.4871, subdivision 9a, must
202.23 be offered to each client's family.

202.24 Subd. 3. **Provider requirements.** A children's therapeutic services and supports license
202.25 holder must be enrolled with medical assistance and comply with the requirements in section
202.26 256B.0943.

202.27 Subd. 4. **Qualifications of provider staff.** Children's therapeutic services and supports
202.28 must be provided by:

202.29 (1) a mental health professional qualified under section 245I.04, subdivision 2;

202.30 (2) a clinical trainee qualified under section 245I.04, subdivision 6;

202.31 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

203.1 (4) a mental health certified family peer specialist qualified under section 245I.04,
203.2 subdivision 12; or

203.3 (5) a mental health behavioral aide qualified under section 245I.04, subdivision 16.

203.4 Subd. 5. **Group modality.** Group skills training may be provided to multiple clients
203.5 who, because of the nature of the clients' emotional, behavioral, or social dysfunction, can
203.6 derive mutual benefit from interaction in a group setting. A group must consist of two to
203.7 ten clients, at least one of whom is a client and is concurrently receiving a service under
203.8 this section. The service and group must be specified in the client's individual treatment
203.9 plan.

203.10 Sec. 41. [245I.31] CHILDREN'S DAY TREATMENT.

203.11 Subdivision 1. **Generally.** (a) For the purposes of this section, "children's day treatment
203.12 program" means a site-based structured mental health program consisting of psychotherapy
203.13 and individual or group skills training provided by a team under the treatment supervision
203.14 of a mental health professional.

203.15 (b) A children's day treatment program must be licensed for a specific location of
203.16 operation and must not be part of inpatient or residential treatment services.

203.17 (c) A children's day treatment program must stabilize a client's mental health status while
203.18 developing and improving the client's independent living and socialization skills. The goal
203.19 of the day treatment program must be to reduce or relieve the effects of mental illness and
203.20 provide training to enable the client to live in the community.

203.21 (d) Beginning January 1, 2028, a provider of children's day services must be licensed
203.22 under this section and chapter 245A.

203.23 Subd. 2. **Service components.** A children's day treatment program must be capable of
203.24 providing the services in section 245I.30, subdivision 2.

203.25 Subd. 3. **Provider requirements.** A children's day treatment license holder must:

203.26 (1) be enrolled as a provider with medical assistance;

203.27 (2) maintain a policy regarding the use of restrictive procedures and meet the requirements
203.28 of section 245.8261;

203.29 (3) maintain a policy on medications in accordance with section 245I.11, subdivision
203.30 6; and

203.31 (4) meet group modality requirements in section 245I.30, subdivision 5.

204.1 Subd. 4. **Qualifications of provider staff.** Children's day treatment services must be
204.2 provided by:

204.3 (1) a mental health professional qualified under section 245I.04, subdivision 2;

204.4 (2) a clinical trainee qualified under section 245I.04, subdivision 6; or

204.5 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4.

204.6 Sec. 42. Minnesota Statutes 2024, section 256B.0623, subdivision 1, is amended to read:

204.7 Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically
204.8 necessary adult rehabilitative mental health services when the services are provided by an
204.9 entity ~~meeting the standards in this section~~ licensed under section 245I.24. The provider
204.10 entity must make reasonable and good faith efforts to report individual client outcomes to
204.11 the commissioner, using instruments and protocols approved by the commissioner.

204.12 **EFFECTIVE DATE.** This section is effective January 1, 2028.

204.13 Sec. 43. Minnesota Statutes 2024, section 256B.0623, subdivision 3, is amended to read:

204.14 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

204.15 (1) is age 18 or older;

204.16 (2) is diagnosed with a medical condition, such as mental illness or traumatic brain
204.17 injury, for which adult rehabilitative mental health services are needed;

204.18 (3) has substantial disability and functional impairment in three or more of the areas
204.19 listed in section 245I.10, subdivision 9, paragraph (a), clause (4), so that self-sufficiency is
204.20 markedly reduced; and

204.21 (4) has had a recent standard diagnostic assessment pursuant to section 245I.10,
204.22 subdivision 6, by a qualified professional that documents adult rehabilitative mental health
204.23 services are medically necessary to address identified disability and functional impairments
204.24 and individual recipient goals.

204.25 **EFFECTIVE DATE.** This section is effective January 1, 2028.

204.26 Sec. 44. Minnesota Statutes 2024, section 256B.0623, subdivision 12, is amended to read:

204.27 Subd. 12. **Additional requirements.** ~~(a) Providers of adult rehabilitative mental health~~
204.28 ~~services must comply with the requirements relating to referrals for case management in~~
204.29 ~~section 245.467, subdivision 4.~~

205.1 ~~(b) Adult rehabilitative mental health services are provided for most recipients in the~~
205.2 ~~recipient's home and community. Services may also be provided at the home of a relative~~
205.3 ~~or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom,~~
205.4 ~~or other places in the community. (a) Except for "transition to community services," the~~
205.5 ~~place of service does not include a regional treatment center, nursing home, residential~~
205.6 ~~treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36),~~
205.7 ~~or section 245I.23, or an acute care hospital.~~

205.8 ~~(c) Adult rehabilitative mental health services may be provided in group settings if~~
205.9 ~~appropriate to each participating recipient's needs and individual treatment plan. A group~~
205.10 ~~is defined as two to ten clients, at least one of whom is a recipient, who is concurrently~~
205.11 ~~receiving a service which is identified in this section. The service and group must be specified~~
205.12 ~~in the recipient's individual treatment plan. (b) No more than two qualified staff may bill~~
205.13 ~~Medicaid for services provided to the same group of recipients. If two adult rehabilitative~~
205.14 ~~mental health workers bill for recipients in the same group session, they must each bill for~~
205.15 ~~different recipients.~~

205.16 ~~(d) (c) Adult rehabilitative mental health services are appropriate if provided to enable~~
205.17 ~~a recipient to retain stability and functioning, when the recipient is at risk of significant~~
205.18 ~~functional decompensation or requiring more restrictive service settings without these~~
205.19 ~~services.~~

205.20 ~~(e) Adult rehabilitative mental health services instruct, assist, and support the recipient~~
205.21 ~~in areas including: interpersonal communication skills, community resource utilization and~~
205.22 ~~integration skills, crisis planning, relapse prevention skills, health care directives, budgeting~~
205.23 ~~and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills,~~
205.24 ~~transportation skills, medication education and monitoring, mental illness symptom~~
205.25 ~~management skills, household management skills, employment-related skills, parenting~~
205.26 ~~skills, and transition to community living services.~~

205.27 ~~(f) Community intervention, including consultation with relatives, guardians, friends,~~
205.28 ~~employers, treatment providers, and other significant individuals, is appropriate when~~
205.29 ~~directed exclusively to the treatment of the client.~~

205.30 **EFFECTIVE DATE.** This section is effective January 1, 2028.

206.1 Sec. 45. Minnesota Statutes 2024, section 256B.0624, subdivision 1, is amended to read:

206.2 Subdivision 1. **Scope.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically
206.3 necessary crisis response services when the services are provided according to the standards
206.4 in ~~this section~~ 245I.24.

206.5 (b) ~~Subject to federal approval,~~ Medical assistance covers medically necessary residential
206.6 crisis stabilization for adults when the services are provided by an entity licensed under and
206.7 meeting the standards in section 245I.23 or an entity with an adult foster care license meeting
206.8 the standards in ~~this section~~ subdivision 7a.

206.9 (c) The provider entity must make reasonable and good faith efforts to report individual
206.10 client outcomes to the commissioner using instruments and protocols approved by the
206.11 commissioner.

206.12 **EFFECTIVE DATE.** This section is effective January 1, 2028.

206.13 Sec. 46. Minnesota Statutes 2024, section 256B.0624, subdivision 4, is amended to read:

206.14 Subd. 4. **Provider entity standards.** (a) A mobile crisis provider must be:

206.15 (1) a county board operated entity;

206.16 (2) an Indian health services facility or facility owned and operated by a tribe or Tribal
206.17 organization operating under United States Code, title 325, section 450f; or

206.18 (3) a provider entity that is under contract with the county board in the county where
206.19 the potential crisis or emergency is occurring. To provide services under this section, the
206.20 provider entity must directly provide the services; or if services are subcontracted, the
206.21 provider entity must maintain responsibility for services and billing.

206.22 ~~(b) A mobile crisis provider must meet the following standards:~~

206.23 ~~(1) ensure that crisis screenings, crisis assessments, and crisis intervention services are~~
206.24 ~~available to a recipient 24 hours a day, seven days a week;~~

206.25 ~~(2) be able to respond to a call for services in a designated service area or according to~~
206.26 ~~a written agreement with the local mental health authority for an adjacent area;~~

206.27 ~~(3) have at least one mental health professional on staff at all times and at least one~~
206.28 ~~additional staff member capable of leading a crisis response in the community; and~~

206.29 ~~(4) provide the commissioner with information about the number of requests for service,~~
206.30 ~~the number of people that the provider serves face-to-face, outcomes, and the protocols that~~
206.31 ~~the provider uses when deciding when to respond in the community.~~

207.1 ~~(e) A provider entity that provides crisis stabilization services in a residential setting~~
207.2 ~~under subdivision 7 is not required to meet the requirements of paragraphs (a) and (b), but~~
207.3 ~~must meet all other requirements of this subdivision.~~

207.4 ~~(d) A crisis services provider must have the capacity to meet and carry out the standards~~
207.5 ~~in section 245I.011, subdivision 5, and the following standards:~~

207.6 ~~(1) ensures that staff persons provide support for a recipient's family and natural supports,~~
207.7 ~~by enabling the recipient's family and natural supports to observe and participate in the~~
207.8 ~~recipient's treatment, assessments, and planning services;~~

207.9 ~~(2) has adequate administrative ability to ensure availability of services;~~

207.10 ~~(3) is able to ensure that staff providing these services are skilled in the delivery of~~
207.11 ~~mental health crisis response services to recipients;~~

207.12 ~~(4) is able to ensure that staff are implementing culturally specific treatment identified~~
207.13 ~~in the crisis treatment plan that is meaningful and appropriate as determined by the recipient's~~
207.14 ~~culture, beliefs, values, and language;~~

207.15 ~~(5) is able to ensure enough flexibility to respond to the changing intervention and care~~
207.16 ~~needs of a recipient as identified by the recipient or family member during the service~~
207.17 ~~partnership between the recipient and providers;~~

207.18 ~~(6) is able to ensure that staff have the communication tools and procedures to~~
207.19 ~~communicate and consult promptly about crisis assessment and interventions as services~~
207.20 ~~occur;~~

207.21 ~~(7) is able to coordinate these services with county emergency services, community~~
207.22 ~~hospitals, ambulance, transportation services, social services, law enforcement, engagement~~
207.23 ~~services, and mental health crisis services through regularly scheduled interagency meetings;~~

207.24 ~~(8) is able to ensure that services are coordinated with other behavioral health service~~
207.25 ~~providers, county mental health authorities, or federally recognized American Indian~~
207.26 ~~authorities and others as necessary, with the consent of the recipient or parent or guardian.~~
207.27 ~~Services must also be coordinated with the recipient's case manager if the recipient is~~
207.28 ~~receiving case management services;~~

207.29 ~~(9) is able to ensure that crisis intervention services are provided in a manner consistent~~
207.30 ~~with sections 245.461 to 245.486 and 245.487 to 245.489;~~

207.31 ~~(10) is able to coordinate detoxification services for the recipient according to Minnesota~~
207.32 ~~Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;~~

208.1 ~~(11) is able to establish and maintain a quality assurance and evaluation plan to evaluate~~
208.2 ~~the outcomes of services and recipient satisfaction; and~~

208.3 ~~(12) is an enrolled medical assistance provider.~~

208.4 (b) A mobile crisis provider must ensure services are provided consistent with section
208.5 245.469, subdivisions 1 and 2.

208.6 **EFFECTIVE DATE.** This section is effective January 1, 2028.

208.7 Sec. 47. Minnesota Statutes 2024, section 256B.0624, is amended by adding a subdivision
208.8 to read:

208.9 Subd. 7a. **Residential crisis stabilization services in adult foster care settings.** (a) If
208.10 crisis stabilization services are provided in a supervised, licensed residential setting that
208.11 serves no more than four adult residents, and one or more individuals are present at the
208.12 setting to receive residential crisis stabilization, the residential setting staff must include,
208.13 for at least eight hours per day, at least one mental health professional, clinical trainee,
208.14 certified rehabilitation specialist, or mental health practitioner.

208.15 (b) The commissioner must establish a statewide per diem rate for crisis stabilization
208.16 services provided under this paragraph to medical assistance enrollees. The rate for a provider
208.17 must not exceed the rate charged by that provider for the same service to other payers.
208.18 Payment must not be made to more than one entity for each individual for services provided
208.19 under this paragraph on a given day. The commissioner must set rates prospectively for the
208.20 annual rate period. The commissioner must require providers to submit annual cost reports
208.21 on a uniform cost reporting form and use submitted cost reports to inform the rate-setting
208.22 process. The commissioner must recalculate the statewide per diem every year.

208.23 (c) A provider under this subdivision must follow the requirements under section 245I.24,
208.24 subdivisions 4, paragraphs (c) and (d), and 9.

208.25 **EFFECTIVE DATE.** This section is effective January 1, 2028.

208.26 Sec. 48. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 5m, is
208.27 amended to read:

208.28 Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical
208.29 assistance covers services provided by a not-for-profit certified community behavioral health
208.30 clinic (CCBHC) that meets the requirements of section ~~245.735, subdivision 3~~ 245I.17.

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

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

209.9 (1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each
209.10 CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable
209.11 CCBHC costs divided by the total annual number of CCBHC visits. For calculating the
209.12 payment rate, total annual visits include visits covered by medical assistance and visits not
209.13 covered by medical assistance. Allowable costs include but are not limited to the salaries
209.14 and benefits of medical assistance providers; the cost of CCBHC services provided under
209.15 section ~~245.735, subdivision 3, paragraph (a), clauses (6) and (7)~~ 245I.17, subdivision 4;
209.16 and other costs such as insurance or supplies needed to provide CCBHC services;

209.17 (2) payment shall be limited to one payment per day per medical assistance enrollee
209.18 when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement
209.19 if at least one of the CCBHC services listed under section ~~245.735, subdivision 3, paragraph~~
209.20 ~~(a), clause (6)~~ 245I.17, subdivision 4, is furnished to a medical assistance enrollee by a
209.21 health care practitioner or licensed agency employed by or under contract with a CCBHC;

209.22 (3) initial CCBHC daily bundled rates for newly ~~certified~~ licensed CCBHCs under
209.23 section ~~245.735, subdivision 3~~ 245I.17, shall be established by the commissioner using a
209.24 provider-specific rate based on the newly ~~certified~~ licensed CCBHC's audited historical
209.25 cost report data adjusted for the expected cost of delivering CCBHC services. Estimates
209.26 are subject to review by the commissioner and must include the expected cost of providing
209.27 the full scope of CCBHC services and the expected number of visits for the rate period;

209.28 (4) the commissioner shall rebase CCBHC rates once every two years following the last
209.29 rebasing and no less than 12 months following an initial rate or a rate change due to a change
209.30 in the scope of services. For CCBHCs certified after September 30, 2020, and before January
209.31 1, 2021, the commissioner shall rebase rates according to this clause for services provided
209.32 on or after January 1, 2024;

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

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

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

210.9 (8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each
210.10 provider-specific rate by the Medicare Economic Index for primary care services. This
210.11 update shall occur each year in between rebasing periods determined by the commissioner
210.12 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state
210.13 annually using the CCBHC cost report established by the commissioner; and

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

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

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

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

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

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

211.9 (4) a CCBHC must provide the commissioner with data needed to determine incentive
211.10 payment eligibility within six months following the measurement year. The commissioner
211.11 shall notify CCBHC providers of their performance on the required measures and the
211.12 incentive payment amount within 12 months following the measurement year.

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

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

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

211.23 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
211.24 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
211.25 the following year. If the conditions in this paragraph are met between July 1 and December
211.26 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
211.27 on July 1 of the following year.

211.28 (g) Peer services provided by a CCBHC ~~certified~~ licensed under section ~~245.735~~ 245I.17
211.29 are a covered service under medical assistance when a licensed mental health professional
211.30 or alcohol and drug counselor determines that peer services are medically necessary.
211.31 Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility
211.32 standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph
211.33 (b), clause (2).

212.1 **EFFECTIVE DATE.** This section is effective January 1, 2028.

212.2 Sec. 49. Minnesota Statutes 2024, section 256B.0943, subdivision 2, is amended to read:

212.3 Subd. 2. **Covered service components of children's therapeutic services and**
212.4 **supports.** (a) Subject to federal approval, medical assistance covers medically necessary
212.5 children's therapeutic services and supports when the services are provided by an eligible
212.6 provider entity ~~certified under and meeting the standards in this section~~ licensed under
212.7 section 245I.30 or children's day treatment services licensed under section 245I.31. The
212.8 provider entity must make reasonable and good faith efforts to report individual client
212.9 outcomes to the commissioner, using instruments and protocols approved by the
212.10 commissioner.

212.11 (b) The covered service components of children's therapeutic services and supports are:

212.12 ~~(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis,~~
212.13 ~~and group psychotherapy;~~

212.14 ~~(2) individual, family, or group skills training provided by a mental health professional,~~
212.15 ~~clinical trainee, or mental health practitioner;~~

212.16 ~~(3) crisis planning;~~

212.17 ~~(4) mental health behavioral aide services;~~

212.18 (1) the services described in section 245I.30, subdivision 2, provided by providers
212.19 licensed under section 245I.30 or 245I.31;

212.20 (2) administration of standardized measures;

212.21 ~~(5)~~ (3) direction of a mental health behavioral aide; and

212.22 ~~(6)~~ (4) mental health service plan development; and

212.23 ~~(7) children's day treatment.~~

212.24 (c) In delivering services under this section, a licensed provider entity must ensure that
212.25 psychotherapy to address a child's underlying mental health disorder is documented as part
212.26 of the child's ongoing treatment. A provider must deliver or arrange for medically necessary
212.27 psychotherapy unless the child's parent or caregiver chooses not to receive the psychotherapy
212.28 or the provider determines that psychotherapy is no longer medically necessary. When a
212.29 provider determines that psychotherapy is no longer medically necessary, the provider must
212.30 update required documentation, including but not limited to the individual treatment plan,
212.31 the child's medical record, or other authorizations, to include the determination. When a

213.1 provider determines that a child needs psychotherapy but psychotherapy cannot be delivered
 213.2 due to a shortage of licensed mental health professionals in the child's community, the
 213.3 provider must document the lack of access in the child's medical record.

213.4 (d) Medical assistance covers service plan development before completion of a child's
 213.5 individual treatment plan. Service plan development consists of development, review, and
 213.6 revision of the individual treatment plan by face-to-face or electronic communication,
 213.7 including time spent gathering client history from other key figures or providers. The provider
 213.8 must document events, including the time spent with the family and other key participants
 213.9 in the child's life to approve the individual treatment plan. Service plan development is
 213.10 covered only if a treatment plan is completed or for work already completed at the time the
 213.11 client voluntarily chooses to disengage with services for the child. If it is determined upon
 213.12 review that a treatment plan was not completed for the child, the commissioner shall recover
 213.13 the payment for the service plan development.

213.14 (e) Medical assistance covers time spent administering and reporting standardized
 213.15 measures approved by the commissioner.

213.16 **EFFECTIVE DATE.** This section is effective January 1, 2028.

213.17 Sec. 50. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 3, is
 213.18 amended to read:

213.19 **Subd. 3. Determination of client eligibility.** (a) A client's eligibility to receive children's
 213.20 therapeutic services and supports under this section shall be determined based on a standard
 213.21 diagnostic assessment by a mental health professional or a clinical trainee that is performed
 213.22 within one year before the initial start of service and updated as required under section
 213.23 245I.10, subdivision 2. The standard diagnostic assessment must:

213.24 (1) ~~determine whether a child under age 18 has a diagnosis of mental illness or, if the~~
 213.25 ~~person is between the ages of 18 and 21, whether the person has a mental illness; and~~

213.26 (2) document children's therapeutic services and supports as medically necessary to
 213.27 address an identified disability, functional impairment, and the individual client's needs and
 213.28 goals; ~~and.~~

213.29 ~~(3) be used in the development of the individual treatment plan.~~

213.30 (b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to
 213.31 five days of day treatment under this section based on a hospital's medical history and
 213.32 presentation examination of the client.

214.1 ~~(e) Children's therapeutic services and supports include development and rehabilitative~~
214.2 ~~services that support a child's developmental treatment needs.~~

214.3 Sec. 51. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 12, is
214.4 amended to read:

214.5 Subd. 12. **Excluded services.** (a) The following services are not eligible for medical
214.6 assistance payment as children's therapeutic services and supports:

214.7 (1) service components of children's therapeutic services and supports simultaneously
214.8 provided by more than one provider entity unless prior authorization is obtained;

214.9 (2) treatment by multiple providers within the same agency at the same clock time,
214.10 unless one service is delivered to the child and the other service is delivered to the child's
214.11 family or treatment team without the child present;

214.12 (3) children's therapeutic services and supports provided in violation of medical assistance
214.13 policy in Minnesota Rules, part 9505.0220;

214.14 (4) mental health behavioral aide services provided by a personal care assistant who is
214.15 not qualified as a mental health behavioral aide and employed by a certified children's
214.16 therapeutic services and supports provider entity;

214.17 (5) service components of CTSS that are the responsibility of a residential or program
214.18 license holder, including foster care providers under the terms of a service agreement or
214.19 administrative rules governing licensure; and

214.20 (6) adjunctive activities that may be offered by a provider entity but are not otherwise
214.21 covered by medical assistance, including:

214.22 (i) a service that is primarily recreation oriented or that is provided in a setting that is
214.23 not medically supervised. This includes sports activities, exercise groups, activities such as
214.24 craft hours, leisure time, social hours, meal or snack time, trips to community activities,
214.25 and tours;

214.26 (ii) a social or educational service that does not have or cannot reasonably be expected
214.27 to have a therapeutic outcome related to the client's mental illness;

214.28 (iii) prevention or education programs provided to the community; and

214.29 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

215.1 (b) Time spent on administrative tasks before and after providing direct services, including
215.2 scheduling or maintaining clinical records, is included in CTSS payments and may not be
215.3 separately billed as additional clock hours of service.

215.4 Sec. 52. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended
215.5 to read:

215.6 Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency
215.7 responsible for investigating allegations of maltreatment in child foster care, family child
215.8 care, legally nonlicensed child care, and reports involving children served by an unlicensed
215.9 personal care provider organization under section 256B.0659. Copies of findings related to
215.10 personal care provider organizations under section 256B.0659 must be forwarded to the
215.11 Department of Human Services provider enrollment.

215.12 (b) The Department of Human Services is the agency responsible for screening and
215.13 investigating allegations of maltreatment in juvenile correctional facilities listed under
215.14 section 241.021 located in the local welfare agency's county and in facilities licensed or
215.15 certified under chapters 245A and 245D.

215.16 (c) The Department of Health is the agency responsible for screening and investigating
215.17 allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43
215.18 to 144A.482 or chapter 144H.

215.19 (d) The Department of Education is the agency responsible for screening and investigating
215.20 allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11,
215.21 and 13, and chapter 124E. The Department of Education's responsibility to screen and
215.22 investigate includes allegations of maltreatment involving students 18 through 21 years of
215.23 age, including students receiving special education services, up to and including graduation
215.24 and the issuance of a secondary or high school diploma.

215.25 (e) The Department of Human Services is the agency responsible for screening and
215.26 investigating allegations of maltreatment of minors in an EIDBI agency operating under
215.27 sections 245A.142 and 256B.0949.

215.28 (f) A health or corrections agency receiving a report may request the local welfare agency
215.29 to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

215.30 (g) The Department of Children, Youth, and Families is the agency responsible for
215.31 screening and investigating allegations of maltreatment in facilities or programs not listed
215.32 in paragraph (a) that are licensed or certified under chapters 142B and 142C.

216.1 (h) The Department of Human Services is the agency responsible for screening and
216.2 investigating allegations of maltreatment of minors for mobile crisis response services and
216.3 children's therapeutic services and supports programs licensed under chapter 245I.

216.4 Sec. 53. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended
216.5 to read:

216.6 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
216.7 administrative agency responsible for investigating reports made under section 626.557.

216.8 (a) The Department of Health is the lead investigative agency for facilities or services
216.9 licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding
216.10 care homes, hospice providers, residential facilities that are also federally certified as
216.11 intermediate care facilities that serve people with developmental disabilities, or any other
216.12 facility or service not listed in this subdivision that is licensed or required to be licensed by
216.13 the Department of Health for the care of vulnerable adults. "Home care provider" has the
216.14 meaning provided in section 144A.43, subdivision 4, and applies when care or services are
216.15 delivered in the vulnerable adult's home.

216.16 (b) The Department of Human Services is the lead investigative agency for facilities or
216.17 services licensed or required to be licensed as adult day care, adult foster care, community
216.18 residential settings, programs for people with disabilities, EIDBI agencies, family adult day
216.19 services, mental health programs licensed under chapter 245I, mental health clinics, substance
216.20 use disorder programs, the Minnesota Sex Offender Program, or any other facility or service
216.21 not listed in this subdivision that is licensed or required to be licensed by the Department
216.22 of Human Services. The Department of Human Services is also the lead investigative agency
216.23 for unlicensed EIDBI agencies under section 256B.0949. The Department of Human Services
216.24 is the lead investigative agency for adult rehabilitative mental health services under section
216.25 245I.22, mobile crisis response services under section 245I.24, and certified community
216.26 behavioral health clinics under section 245I.17.

216.27 (c) The county social service agency or its designee is the lead investigative agency for
216.28 all other reports, including but not limited to reports involving vulnerable adults receiving
216.29 services from a personal care provider organization under section 256B.0659.

216.30 **EFFECTIVE DATE.** This section is effective January 1, 2028.

217.1 Sec. 54. **REVISOR INSTRUCTION.**

217.2 The revisor of statutes shall renumber Minnesota Statutes, section 245.735, subdivisions
217.3 5 and 6, as Minnesota Statutes, section 245I.17, subdivisions 23 and 24.

217.4 Sec. 55. **REPEALER.**

217.5 (a) Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e,
217.6 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, and 8; 245C.03, subdivision 7; 245I.20, subdivision 9; 245I.23,
217.7 subdivision 23; 256B.0623, subdivisions 2, 4, 5, 6, and 9; 256B.0624, subdivisions 2, 3,
217.8 4a, 5, 6, 6a, 6b, 7, 8, 9, and 11; and 256B.0943, subdivisions 4, 5, 5a, 6, 7, and 11, are
217.9 repealed.

217.10 (b) Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3 and 4d; and
217.11 256B.0943, subdivisions 1 and 9, are repealed.

217.12 **EFFECTIVE DATE.** This section is effective January 1, 2028.

217.13

ARTICLE 6

217.14

UNIFORM SERVICE STANDARDS CONFORMING CHANGES

217.15 Section 1. Minnesota Statutes 2024, section 13.46, subdivision 7, is amended to read:

217.16 Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals and
217.17 shall not be disclosed, except:

217.18 (1) pursuant to section 13.05, as determined by the responsible authority for the
217.19 community mental health center, mental health division, or provider;

217.20 (2) pursuant to court order;

217.21 (3) pursuant to a statute specifically authorizing access to or disclosure of mental health
217.22 data or as otherwise provided by this subdivision;

217.23 (4) to personnel of the welfare system working in the same program or providing services
217.24 to the same individual or family to the extent necessary to coordinate services, provided
217.25 that a health record may be disclosed only as provided under section 144.293;

217.26 (5) to a health care provider governed by sections 144.291 to 144.298, to the extent
217.27 necessary to coordinate services; or

217.28 (6) with the consent of the client or patient.

217.29 (b) An agency of the welfare system may not require an individual to consent to the
217.30 release of mental health data as a condition for receiving services or for reimbursing a

218.1 community mental health center, mental health division of a county, or provider under
218.2 contract to deliver mental health services.

218.3 (c) Notwithstanding any other law to the contrary, a community mental health center,
218.4 mental health division of a county, or a mental health provider must disclose mental health
218.5 data to a law enforcement agency if the law enforcement agency provides the name of a
218.6 client or patient and communicates that the:

218.7 (1) client or patient is currently involved in a mental health crisis as defined in section
218.8 ~~256B.0624, subdivision 2, paragraph (j)~~ 245I.24, subdivision 2, paragraph (g), to which the
218.9 law enforcement agency has responded; and

218.10 (2) data is necessary to protect the health or safety of the client or patient or of another
218.11 person.

218.12 The scope of disclosure under this paragraph is limited to the minimum necessary for
218.13 law enforcement to safely respond to the mental health crisis. Disclosure under this paragraph
218.14 may include the name and telephone number of the psychiatrist, psychologist, therapist,
218.15 mental health professional, practitioner, or case manager of the client or patient, if known;
218.16 and strategies to address the mental health crisis. A law enforcement agency that obtains
218.17 mental health data under this paragraph shall maintain a record of the requestor, the provider
218.18 of the data, and the client or patient name. Mental health data obtained by a law enforcement
218.19 agency under this paragraph are private data on individuals and must not be used by the
218.20 law enforcement agency for any other purpose. A law enforcement agency that obtains
218.21 mental health data under this paragraph shall inform the subject of the data that mental
218.22 health data was obtained.

218.23 (d) In the event of a request under paragraph (a), clause (6), a community mental health
218.24 center, county mental health division, or provider must release mental health data to Criminal
218.25 Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal
218.26 Mental Health Court personnel communicate that the:

218.27 (1) client or patient is a defendant in a criminal case pending in the district court;

218.28 (2) data being requested is limited to information that is necessary to assess whether the
218.29 defendant is eligible for participation in the Criminal Mental Health Court; and

218.30 (3) client or patient has consented to the release of the mental health data and a copy of
218.31 the consent will be provided to the community mental health center, county mental health
218.32 division, or provider within 72 hours of the release of the data.

219.1 For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty
219.2 criminal calendar of the Hennepin County District Court for defendants with mental illness
219.3 and brain injury where a primary goal of the calendar is to assess the treatment needs of the
219.4 defendants and to incorporate those treatment needs into voluntary case disposition plans.
219.5 The data released pursuant to this paragraph may be used for the sole purpose of determining
219.6 whether the person is eligible for participation in mental health court. This paragraph does
219.7 not in any way limit or otherwise extend the rights of the court to obtain the release of mental
219.8 health data pursuant to court order or any other means allowed by law.

219.9 Sec. 2. Minnesota Statutes 2024, section 144.294, subdivision 2, is amended to read:

219.10 Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293,
219.11 subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental
219.12 health to a law enforcement agency if the law enforcement agency provides the name of
219.13 the patient and communicates that the:

219.14 (1) patient is currently involved in a mental health crisis as defined in section ~~256B.0624,~~
219.15 ~~subdivision 2, paragraph (j)~~ 245I.24, subdivision 2, paragraph (g), to which the law
219.16 enforcement agency has responded; and

219.17 (2) disclosure of the records is necessary to protect the health or safety of the patient or
219.18 of another person.

219.19 The scope of disclosure under this subdivision is limited to the minimum necessary for
219.20 law enforcement to safely respond to the mental health crisis. The disclosure may include
219.21 the name and telephone number of the psychiatrist, psychologist, therapist, mental health
219.22 professional, practitioner, or case manager of the patient, if known; and strategies to address
219.23 the mental health crisis. A law enforcement agency that obtains health records under this
219.24 subdivision shall maintain a record of the requestor, the provider of the information, and
219.25 the patient's name. Health records obtained by a law enforcement agency under this
219.26 subdivision are private data on individuals as defined in section 13.02, subdivision 12, and
219.27 must not be used by law enforcement for any other purpose. A law enforcement agency that
219.28 obtains health records under this subdivision shall inform the patient that health records
219.29 were obtained.

219.30 Sec. 3. Minnesota Statutes 2025 Supplement, section 245.4835, subdivision 2, is amended
219.31 to read:

219.32 Subd. 2. **Failure to maintain expenditures.** (a) If a county does not comply with
219.33 subdivision 1, the commissioner shall require the county to develop a corrective action plan

220.1 according to a format and timeline established by the commissioner. If the commissioner
220.2 determines that a county has not developed an acceptable corrective action plan within the
220.3 required timeline, or that the county is not in compliance with an approved corrective action
220.4 plan, the protections provided to that county under section 245.485 do not apply.

220.5 (b) The commissioner shall consider the following factors to determine whether to
220.6 approve a county's corrective action plan:

220.7 (1) the degree to which a county is maximizing revenues for mental health services from
220.8 noncounty sources;

220.9 (2) the degree to which a county is expanding use of alternative services that meet mental
220.10 health needs, but do not count as mental health services within existing reporting systems.
220.11 If approved by the commissioner, the alternative services must be included in the county's
220.12 base as well as subsequent years. The commissioner's approval for alternative services must
220.13 be based on the following criteria:

220.14 (i) the service must be provided to children or adults with mental illness;

220.15 (ii) the services must be based on an individual treatment plan or individual community
220.16 support plan as defined in the Comprehensive Mental Health Act; and

220.17 (iii) the services must be supervised by a mental health professional and provided by
220.18 staff who meet the staff qualifications defined in sections ~~256B.0943, subdivision 7~~ 245I.30,
220.19 subdivision 4, and ~~256B.0623, subdivision 5~~ 245I.22, subdivision 5.

220.20 (c) Additional county expenditures to make up for the prior year's underspending may
220.21 be spread out over a two-year period.

220.22 Sec. 4. Minnesota Statutes 2025 Supplement, section 245.4871, subdivision 4, is amended
220.23 to read:

220.24 Subd. 4. **Case management service provider.** (a) "Case management service provider"
220.25 means a case manager or case manager associate employed by the county or other entity
220.26 authorized by the county board to provide case management services specified in subdivision
220.27 3 for the child with serious mental illness and the child's family.

220.28 (b) A case manager must:

220.29 (1) have experience and training in working with children;

220.30 (2) be a mental health practitioner under section 245I.04, subdivision 4, or have at least
220.31 a bachelor's degree in one of the behavioral sciences or a related field including, but not

221.1 limited to, social work, psychology, or nursing from an accredited college or university or
221.2 meet the requirements of paragraph (d);

221.3 (3) have experience and training in identifying and assessing a wide range of children's
221.4 needs;

221.5 (4) be knowledgeable about local community resources and how to use those resources
221.6 for the benefit of children and their families; and

221.7 (5) meet the supervision and continuing education requirements of paragraphs (e), (f),
221.8 and (g), as applicable.

221.9 (c) A case manager may be a member of any professional discipline that is part of the
221.10 local system of care for children established by the county board.

221.11 (d) A case manager who is not a mental health practitioner and does not have a bachelor's
221.12 degree or who has a bachelor's degree that is not in one of the behavioral sciences or related
221.13 fields must meet one of the requirements in clauses (1) to (5):

221.14 (1) have three or four years of experience as a case manager associate;

221.15 (2) be a registered nurse without a bachelor's degree who has a combination of specialized
221.16 training in psychiatry and work experience consisting of community interaction and
221.17 involvement or community discharge planning in a mental health setting totaling three years;

221.18 (3) be a person who qualified as a case manager under the 1998 Department of Human
221.19 Services waiver provision and meets the continuing education, supervision, and mentoring
221.20 requirements in this section;

221.21 (4) prior to direct service delivery, complete at least 80 hours of specific training on the
221.22 characteristics and needs of children with serious mental illness that is consistent with
221.23 national practices standards; or

221.24 (5) prior to direct service delivery, demonstrate competency in practice and knowledge
221.25 of the characteristics and needs of children with serious mental illness, consistent with
221.26 national practices standards.

221.27 (e) A case manager with at least 2,000 hours of supervised experience in the delivery
221.28 of mental health services to children must receive regular ongoing supervision and clinical
221.29 supervision totaling 38 hours per year, of which at least one hour per month must be clinical
221.30 supervision regarding individual service delivery with a case management supervisor. The
221.31 other 26 hours of supervision may be provided by a case manager with two years of

222.1 experience. Group supervision may not constitute more than one-half of the required
222.2 supervision hours.

222.3 (f) A case manager without 2,000 hours of supervised experience in the delivery of
222.4 mental health services to children with mental illness must:

222.5 (1) begin 40 hours of training approved by the commissioner of human services in case
222.6 management skills and in the characteristics and needs of children with serious mental
222.7 illness before beginning to provide case management services; and

222.8 (2) receive clinical supervision regarding individual service delivery from a mental
222.9 health professional at least one hour each week until the requirement of 2,000 hours of
222.10 experience is met.

222.11 (g) A case manager who is not licensed, registered, or certified by a health-related
222.12 licensing board must receive 30 hours of continuing education and training in serious mental
222.13 illness and mental health services every two years.

222.14 (h) Clinical supervision must be documented in the child's record. When the case manager
222.15 is not a mental health professional, the county board must provide or contract for needed
222.16 clinical supervision.

222.17 (i) The county board must ensure that the case manager has the freedom to access and
222.18 coordinate the services within the local system of care that are needed by the child.

222.19 (j) A case manager associate (CMA) must:

222.20 (1) work under the direction of a case manager or case management supervisor;

222.21 (2) be at least 21 years of age;

222.22 (3) have at least a high school diploma or its equivalent; and

222.23 (4) meet one of the following criteria:

222.24 (i) have an associate of arts degree in one of the behavioral sciences or human services;

222.25 (ii) be a registered nurse without a bachelor's degree;

222.26 (iii) have three years of life experience as a primary caregiver to a child with serious
222.27 mental illness as defined in subdivision 6 within the previous ten years;

222.28 (iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

222.29 (v) have 6,000 hours of supervised work experience in the delivery of mental health
222.30 services to children with mental illness; hours worked as a mental health behavioral aide I

223.1 or II under section ~~256B.0943, subdivision 7~~ 245I.30, subdivision 4, may count toward the
223.2 6,000 hours of supervised work experience.

223.3 Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager
223.4 after four years of supervised work experience as a case manager associate. Individuals
223.5 meeting the criteria in item (v) may qualify as a case manager after three years of supervised
223.6 experience as a case manager associate.

223.7 (k) Case manager associates must meet the following supervision, mentoring, and
223.8 continuing education requirements:

223.9 (1) have 40 hours of preservice training described under paragraph (f), clause (1);

223.10 (2) receive at least 40 hours of continuing education in serious mental illness and mental
223.11 health service annually; and

223.12 (3) receive at least five hours of mentoring per week from a case management mentor.

223.13 A "case management mentor" means a qualified, practicing case manager or case management
223.14 supervisor who teaches or advises and provides intensive training and clinical supervision
223.15 to one or more case manager associates. Mentoring may occur while providing direct services
223.16 to consumers in the office or in the field and may be provided to individuals or groups of
223.17 case manager associates. At least two mentoring hours per week must be individual and
223.18 face-to-face.

223.19 (l) A case management supervisor must meet the criteria for a mental health professional
223.20 as specified in subdivision 27.

223.21 (m) An immigrant who does not have the qualifications specified in this subdivision
223.22 may provide case management services to child immigrants with serious mental illness of
223.23 the same ethnic group as the immigrant if the person:

223.24 (1) is currently enrolled in and is actively pursuing credits toward the completion of a
223.25 bachelor's degree in one of the behavioral sciences or related fields at an accredited college
223.26 or university;

223.27 (2) completes 40 hours of training as specified in this subdivision; and

223.28 (3) receives clinical supervision at least once a week until the requirements of obtaining
223.29 a bachelor's degree and 2,000 hours of supervised experience are met.

223.30 Sec. 5. Minnesota Statutes 2024, section 245.4882, subdivision 6, is amended to read:

223.31 Subd. 6. **Crisis admissions and stabilization.** (a) A child may be referred for residential
223.32 treatment services under this section for the purpose of crisis stabilization by:

224.1 (1) a mental health professional as defined in section 245I.04, subdivision 2;
224.2 (2) a physician licensed under chapter 147 who is assessing a child in an emergency
224.3 department; or

224.4 (3) a member of a mobile crisis team who meets the qualifications under section
224.5 ~~256B.0624, subdivision 5~~ 245I.24, subdivision 5.

224.6 (b) A provider making a referral under paragraph (a) must conduct an assessment of the
224.7 child's mental health needs and make a determination that the child is experiencing a mental
224.8 health crisis and is in need of residential treatment services under this section.

224.9 (c) A child may receive services under this subdivision for up to 30 days and must be
224.10 subject to the screening and admissions criteria and processes under section 245.4885
224.11 thereafter.

224.12 Sec. 6. Minnesota Statutes 2025 Supplement, section 245.735, subdivision 4d, is amended
224.13 to read:

224.14 Subd. 4d. **Requirements for integrated treatment plans.** (a) An integrated treatment
224.15 plan must be completed within 60 calendar days following the preliminary screening and
224.16 risk assessment and updated no less frequently than every six months or when the client's
224.17 circumstances change.

224.18 (b) Only a mental health professional may complete an integrated treatment plan. The
224.19 mental health professional must consult with an alcohol and drug counselor when substance
224.20 use disorder services are deemed clinically appropriate. An alcohol and drug counselor may
224.21 approve the integrated treatment plan. The integrated treatment plan must be developed
224.22 through a shared decision-making process with the client, the client's support system if the
224.23 client chooses, or, for children, with the family or caregivers.

224.24 (c) The integrated treatment plan must:

224.25 (1) use the ASAM 6 dimensional framework; and

224.26 (2) incorporate prevention, medical and behavioral health needs, and service delivery.

224.27 (d) The psychiatric evaluation and management service fulfills requirements for the
224.28 integrated treatment plan when a client of a CCBHC is receiving exclusively psychiatric
224.29 evaluation and management services. The CCBHC must complete an integrated treatment
224.30 plan within 60 calendar days of a client's referral for additional CCBHC services.

224.31 (e) Notwithstanding any law to the contrary, an integrated treatment plan developed by
224.32 a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

225.1 (1) section 245G.06, subdivision 1;

225.2 (2) section 245G.09, subdivision 3, paragraph (a), clause (6); and

225.3 (3) section 245I.10, subdivisions 7 and 8; and.

225.4 ~~(4) section 256B.0943, subdivision 6, paragraph (b), clause (2).~~

225.5 Sec. 7. Minnesota Statutes 2024, section 245A.26, subdivision 3, is amended to read:

225.6 Subd. 3. **Eligibility for services.** An individual is eligible for children's residential crisis
225.7 stabilization services if the individual is under 21 years of age and meets the eligibility
225.8 criteria for crisis services under section ~~256B.0624, subdivision 3~~ 245I.24, subdivision 3.

225.9 Sec. 8. Minnesota Statutes 2024, section 245A.26, subdivision 4, is amended to read:

225.10 Subd. 4. **Required services; providers.** (a) A license holder providing residential crisis
225.11 stabilization services must continually follow a client's individual crisis treatment plan to
225.12 improve the client's functioning.

225.13 (b) The license holder must offer and have the capacity to directly provide the following
225.14 treatment services to a client:

225.15 (1) crisis stabilization services as described in section ~~256B.0624, subdivision 7~~ 245I.24,
225.16 subdivision 9;

225.17 (2) mental health services as specified in the client's individual crisis treatment plan,
225.18 according to the client's treatment needs;

225.19 (3) health services and medication administration, if applicable; and

225.20 (4) referrals for the client to community-based treatment providers and support services
225.21 for the client's transition from residential crisis stabilization to another treatment setting.

225.22 (c) Children's residential crisis stabilization services must be provided by a qualified
225.23 staff person listed in section ~~256B.0624, subdivision 8~~ 245I.24, subdivision 9, paragraph
225.24 (b), according to the scope of practice for the individual staff person's position.

225.25 Sec. 9. Minnesota Statutes 2024, section 245A.26, subdivision 5, is amended to read:

225.26 Subd. 5. **Assessment and treatment planning.** (a) Within 12 hours of a client's admission
225.27 for residential crisis stabilization, the license holder must assess the client and document
225.28 the client's immediate needs, including the client's:

225.29 (1) health and safety, including the need for crisis assistance;

226.1 (2) need for connection to family and other natural supports;

226.2 (3) if applicable, housing and legal issues; and

226.3 (4) if applicable, responsibilities for children, family, and other natural supports, and
226.4 employers.

226.5 (b) Within 24 hours of a client's admission for residential crisis stabilization, the license
226.6 holder must complete a crisis treatment plan for the client, according to the requirements
226.7 for a crisis treatment plan under section ~~256B.0624, subdivision 11~~ 245I.24, subdivision
226.8 11. The license holder must base the client's crisis treatment plan on the client's referral
226.9 information and the assessment of the client's immediate needs under paragraph (a). A
226.10 mental health professional or a clinical trainee under the supervision of a mental health
226.11 professional must complete the crisis treatment plan. A crisis treatment plan completed by
226.12 a clinical trainee must contain documentation of approval, as defined in section 245I.02,
226.13 subdivision 2, by a mental health professional within five business days of initial completion
226.14 by the clinical trainee.

226.15 (c) A mental health professional must review a client's crisis treatment plan each week
226.16 and document the weekly reviews in the client's client file.

226.17 (d) For a client receiving children's residential crisis stabilization services who is 18
226.18 years of age or older, the license holder must complete an individual abuse prevention plan
226.19 for the client, pursuant to section 245A.65, subdivision 2, as part of the client's crisis
226.20 treatment plan.

226.21 Sec. 10. Minnesota Statutes 2024, section 245C.10, subdivision 8, is amended to read:

226.22 Subd. 8. **Children's therapeutic services and supports providers.** The commissioner
226.23 shall recover the cost of background studies required under section 245C.03, subdivision
226.24 7, for the purposes of children's therapeutic services and supports under section ~~256B.0943~~
226.25 245I.30, through a fee of no more than \$44 per study charged to the license holder. The fees
226.26 collected under this subdivision are appropriated to the commissioner for the purpose of
226.27 conducting background studies.

226.28 Sec. 11. Minnesota Statutes 2024, section 245I.23, subdivision 5, is amended to read:

226.29 Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the
226.30 license holder must follow a client's individual crisis treatment plan to provide services to
226.31 the client in residential crisis stabilization to improve the client's functioning.

227.1 (b) The license holder must offer and have the capacity to directly provide the following
227.2 treatment services to the client:

227.3 (1) crisis stabilization services as described in section ~~256B.0624, subdivision 7~~ 245I.24,
227.4 subdivision 9;

227.5 (2) rehabilitative mental health services;

227.6 (3) health services and administering the client's medications; and

227.7 (4) making referrals for the client to other service providers in the community and
227.8 supporting the client's transition from residential crisis stabilization to another setting.

227.9 Sec. 12. Minnesota Statutes 2024, section 245I.23, subdivision 8, is amended to read:

227.10 Subd. 8. **Residential crisis stabilization assessment and treatment planning.** (a)

227.11 Within 12 hours of a client's admission, the license holder must evaluate the client and
227.12 document the client's immediate needs, including the client's:

227.13 (1) health and safety, including the client's need for crisis assistance;

227.14 (2) responsibilities for children, family and other natural supports, and employers; and

227.15 (3) housing and legal issues.

227.16 (b) Within 24 hours of a client's admission, the license holder must complete a crisis
227.17 treatment plan for the client under section ~~256B.0624, subdivision 11~~ 245I.24, subdivision
227.18 11. The license holder must base the client's crisis treatment plan on the client's referral
227.19 information and an assessment of the client's immediate needs.

227.20 (c) Section 245A.65, subdivision 2, paragraph (b), requires the license holder to complete
227.21 an individual abuse prevention plan for a client as part of the client's crisis treatment plan.

227.22 Sec. 13. Minnesota Statutes 2024, section 245I.23, subdivision 16, is amended to read:

227.23 Subd. 16. **Residential crisis stabilization services admission criteria.** An eligible client
227.24 for residential crisis stabilization is an individual who is age 18 or older and meets the
227.25 eligibility criteria in section ~~256B.0624, subdivision 3~~ 245I.24, subdivision 3.

227.26 Sec. 14. Minnesota Statutes 2024, section 256B.092, subdivision 14, is amended to read:

227.27 Subd. 14. **Reduce avoidable behavioral crisis emergency room admissions,**
227.28 **psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons
227.29 receiving home and community-based services authorized under this section who have had
227.30 two or more admissions within a calendar year to an emergency room, psychiatric unit, or

228.1 institution must receive consultation from a mental health professional as defined in section
228.2 245.462, subdivision 18, or a behavioral professional as defined in the home and
228.3 community-based services state plan within 30 days of discharge. The mental health
228.4 professional or behavioral professional must:

228.5 (1) conduct a functional assessment of the crisis incident as defined in section 245D.02,
228.6 subdivision 11, which led to the hospitalization with the goal of developing proactive
228.7 strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable
228.8 hospitalizations due to a behavioral crisis;

228.9 (2) use the results of the functional assessment to amend the support plan set forth in
228.10 section 245D.02, subdivision 4b, to address the potential need for additional staff training,
228.11 increased staffing, access to crisis mobility services, mental health services, use of
228.12 technology, and crisis stabilization services in section ~~256B.0624, subdivision 7~~ 245I.24,
228.13 subdivision 9; and

228.14 (3) identify the need for additional consultation, testing, and mental health crisis
228.15 intervention team services as defined in section 245D.02, subdivision 20, psychotropic
228.16 medication use and monitoring under section 245D.051, and the frequency and duration of
228.17 ongoing consultation.

228.18 (b) For the purposes of this subdivision, "institution" includes, but is not limited to, the
228.19 Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

228.20 Sec. 15. Minnesota Statutes 2024, section 256B.49, subdivision 25, is amended to read:

228.21 **Subd. 25. Reduce avoidable behavioral crisis emergency room admissions,**
228.22 **psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons
228.23 receiving home and community-based services authorized under this section who have two
228.24 or more admissions within a calendar year to an emergency room, psychiatric unit, or
228.25 institution must receive consultation from a mental health professional as defined in section
228.26 245.462, subdivision 18, or a behavioral professional as defined in the home and
228.27 community-based services state plan within 30 days of discharge. The mental health
228.28 professional or behavioral professional must:

228.29 (1) conduct a functional assessment of the crisis incident as defined in section 245D.02,
228.30 subdivision 11, which led to the hospitalization with the goal of developing proactive
228.31 strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable
228.32 hospitalizations due to a behavioral crisis;

229.1 (2) use the results of the functional assessment to amend the support plan in section
229.2 245D.02, subdivision 4b, to address the potential need for additional staff training, increased
229.3 staffing, access to crisis mobility services, mental health services, use of technology, and
229.4 crisis stabilization services in section ~~256B.0624, subdivision 7~~ 245I.24, subdivision 9; and

229.5 (3) identify the need for additional consultation, testing, mental health crisis intervention
229.6 team services as defined in section 245D.02, subdivision 20, psychotropic medication use
229.7 and monitoring under section 245D.051, and the frequency and duration of ongoing
229.8 consultation.

229.9 (b) For the purposes of this subdivision, "institution" includes, but is not limited to, the
229.10 Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

229.11 Sec. 16. Minnesota Statutes 2025 Supplement, section 256L.03, subdivision 5, is amended
229.12 to read:

229.13 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to
229.14 children under the age of 21 and to American Indians as defined in Code of Federal
229.15 Regulations, title 42, section 600.5.

229.16 (b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered
229.17 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.
229.18 The cost-sharing changes described in this paragraph do not apply to eligible recipients or
229.19 services exempt from cost-sharing under state law. The cost-sharing changes described in
229.20 this paragraph shall not be implemented prior to January 1, 2016.

229.21 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements
229.22 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,
229.23 title 42, sections 600.510 and 600.520.

229.24 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic
229.25 disease must comply with the requirements of section 62Q.481.

229.26 (e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic
229.27 services or testing that a health care provider determines an enrollee requires after a
229.28 mammogram, as specified under section 62A.30, subdivision 5.

229.29 (f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to
229.30 tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

230.1 (g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis
230.2 (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or
230.3 treatment of the human immunodeficiency virus (HIV).

230.4 (h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention
230.5 or crisis assessment as defined in section ~~256B.0624, subdivision 2~~ 245I.24, subdivision 2.

230.6 ARTICLE 7

230.7 AGING AND DISABILITY SERVICES

230.8 Section 1. Minnesota Statutes 2025 Supplement, section 144.0724, subdivision 11, is
230.9 amended to read:

230.10 Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment
230.11 of long-term care services, a recipient must be determined, using assessments defined in
230.12 subdivision 4, to meet one of the following nursing facility level of care criteria:

230.13 (1) the person requires formal clinical monitoring at least once per day;

230.14 (2) the person needs the assistance of another person or constant supervision to begin
230.15 and complete at least four of the following activities of living: bathing, bed mobility, dressing,
230.16 eating, grooming, toileting, transferring, and walking;

230.17 (3) the person needs the assistance of another person or constant supervision to begin
230.18 and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

230.19 (4) the person has significant difficulty with memory, using information, daily decision
230.20 making, or behavioral needs that require intervention;

230.21 (5) the person has had a qualifying nursing facility stay of at least 90 days;

230.22 (6) the person meets the nursing facility level of care criteria determined 90 days after
230.23 admission or on the first quarterly assessment after admission, whichever is later; or

230.24 (7) the person is determined to be at risk for nursing facility admission or readmission
230.25 ~~through a face-to-face long-term care consultation assessment as specified in section~~
230.26 ~~256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, Tribe, or managed care~~
230.27 ~~organization under contract with the Department of Human Services.~~ The person is
230.28 considered at risk under this clause if the person currently lives alone or will live alone or
230.29 be homeless without the person's current housing and also meets one of the following criteria:

230.30 (i) the person has experienced a fall resulting in a fracture;

231.1 (ii) the person has been determined to be at risk of maltreatment or neglect, including
231.2 self-neglect; or

231.3 (iii) the person has a sensory impairment that substantially impacts functional ability
231.4 and maintenance of a community residence.

231.5 (b) The assessment used to establish medical assistance payment for nursing facility
231.6 services must be the most recent assessment performed under subdivision 4, paragraph (b),
231.7 that occurred no more than 90 calendar days before the effective date of medical assistance
231.8 eligibility for payment of long-term care services. In no case shall medical assistance payment
231.9 for long-term care services occur prior to the date of the determination of nursing facility
231.10 level of care.

231.11 (c) The assessment used to establish medical assistance payment for long-term care
231.12 services provided under chapter 256S and section 256B.49 and alternative care payment
231.13 for services provided under section 256B.0913 must be the most recent face-to-face
231.14 assessment performed under section 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28,
231.15 that occurred no more than one calendar year before the effective date of medical assistance
231.16 eligibility for payment of long-term care services.

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

231.18 Sec. 2. Minnesota Statutes 2024, section 245D.12, is amended to read:

231.19 **245D.12 INTEGRATED COMMUNITY SUPPORTS; ~~SETTING CAPACITY~~**
231.20 **~~REPORT.~~**

231.21 **Subdivision 1. Setting capacity report.** (a) The license holder providing integrated
231.22 community support, as defined in section 245D.03, subdivision 1, paragraph (c), clause (8),
231.23 must submit a setting capacity report to the commissioner to ensure the identified location
231.24 of service delivery meets the criteria of the home and community-based service requirements
231.25 as specified in section 256B.492.

231.26 (b) The license holder shall provide the setting capacity report on the forms and in the
231.27 manner prescribed by the commissioner. The report must include:

231.28 (1) the address of the multifamily housing building where the license holder delivers
231.29 integrated community supports and owns, leases, or has a direct or indirect financial
231.30 relationship with the property owner;

231.31 (2) the total number of living units in the multifamily housing building described in
231.32 clause (1) where integrated community supports are delivered;

232.1 (3) the total number of living units in the multifamily housing building described in
232.2 clause (1), including the living units identified in clause (2);

232.3 (4) the total number of people who could reside in the living units in the multifamily
232.4 housing building described in clause (2) and receive integrated community supports; and

232.5 (5) the percentage of living units that are controlled by the license holder in the
232.6 multifamily housing building by dividing clause (2) by clause (3).

232.7 (c) Only one license holder may deliver integrated community supports at the address
232.8 of the multifamily housing building.

232.9 Subd. 2. **Licensure moratorium.** (a) Except as permitted in this subdivision, the
232.10 commissioner must not issue an initial license under this chapter authorizing integrated
232.11 community supports under section 245D.03, subdivision 1, paragraph (c), clause (8), and
232.12 must not approve a license change adding integrated community supports to an existing
232.13 license under this chapter.

232.14 (b) The commissioner may approve an exception to the moratorium only when the
232.15 applicant or licensee meets all requirements under subdivision 1, the request is not superseded
232.16 by temporary moratoriums under section 245A.03, subdivision 7a, and the applicant submits
232.17 documentation demonstrating compliance with:

232.18 (1) federal and state home and community-based services requirements for
232.19 provider-controlled settings;

232.20 (2) the prohibition on the use of Medicaid money for room and board under United
232.21 States Code, title 42, section 1396n(c); and

232.22 (3) all licensing requirements applicable to integrated community supports under this
232.23 chapter.

232.24 (c) In determining whether to approve an exception, the commissioner must consider
232.25 statewide and regional capacity for integrated community supports based on needs
232.26 determination processes under section 245A.03, subdivision 7, paragraph (e).

232.27 (d) A determination under this subdivision is final and not subject to appeal.

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

232.29 Sec. 3. Minnesota Statutes 2024, section 256.975, subdivision 7b, is amended to read:

232.30 Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal
232.31 screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

233.1 (1) a person who, having entered an acute care facility from a certified nursing facility,
233.2 is returning to a certified nursing facility; or

233.3 (2) a person transferring from one certified nursing facility in Minnesota to another
233.4 certified nursing facility in Minnesota.

233.5 (b) Persons who are exempt from preadmission screening for purposes of level of care
233.6 determination include:

233.7 (1) persons described in paragraph (a);

233.8 (2) an individual who has a contractual right to have nursing facility care paid for
233.9 indefinitely by the Veterans Administration; and

233.10 (3) an individual enrolled in a demonstration project under section 256B.69, subdivision
233.11 8, at the time of application to a nursing facility; and

233.12 ~~(4) an individual currently being served under the alternative care program or under a~~
233.13 ~~home and community-based services waiver authorized under section 1915(e) of the federal~~
233.14 ~~Social Security Act.~~

233.15 (c) Persons admitted to a Medicaid-certified nursing facility from the community on an
233.16 emergency basis as described in paragraph (d) or from an acute care facility on a nonworking
233.17 day must be screened the first working day after admission.

233.18 (d) Emergency admission to a nursing facility prior to screening is permitted when all
233.19 of the following conditions are met:

233.20 (1) a person is admitted from the community to a certified nursing or certified boarding
233.21 care facility during Senior LinkAge Line nonworking hours;

233.22 (2) a physician, advanced practice registered nurse, or physician assistant has determined
233.23 that delaying admission until preadmission screening is completed would adversely affect
233.24 the person's health and safety;

233.25 (3) there is a recent precipitating event that precludes the client from living safely in the
233.26 community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's
233.27 inability to continue to provide care;

233.28 (4) the attending physician, advanced practice registered nurse, or physician assistant
233.29 has authorized the emergency placement and has documented the reason that the emergency
233.30 placement is recommended; and

233.31 (5) the Senior LinkAge Line is contacted on the first working day following the
233.32 emergency admission.

234.1 (e) Transfer of a patient from an acute care hospital to a nursing facility is not considered
234.2 an emergency except for a person who has received hospital services in the following
234.3 situations: hospital admission for observation, care in an emergency room without hospital
234.4 admission, or following hospital 24-hour bed care and from whom admission is being sought
234.5 on a nonworking day.

234.6 (f) A nursing facility must provide written information to all persons admitted regarding
234.7 the person's right to request and receive long-term care consultation services as defined in
234.8 section 256B.0911, subdivision 11. The information must be provided prior to the person's
234.9 discharge from the facility and in a format specified by the commissioner.

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

234.11 Sec. 4. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 17, is
234.12 amended to read:

234.13 Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service"
234.14 means motor vehicle transportation provided by a public or private person that serves
234.15 Minnesota health care program beneficiaries who do not require emergency ambulance
234.16 service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

234.17 (b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means
234.18 a census-tract based classification system under which a geographical area is determined
234.19 to be urban, rural, or super rural. This paragraph expires July 1, 2026, for medical assistance
234.20 fee-for-service and January 1, 2027, for prepaid medical assistance.

234.21 (c) Medical assistance covers medical transportation costs incurred solely for obtaining
234.22 emergency medical care or transportation costs incurred by eligible persons in obtaining
234.23 emergency or nonemergency medical care when paid directly to an ambulance company,
234.24 nonemergency medical transportation company, or other recognized providers of
234.25 transportation services. Medical transportation must be provided by:

234.26 (1) nonemergency medical transportation providers who meet the requirements of this
234.27 subdivision;

234.28 (2) ambulances, as defined in section 144E.001, subdivision 2;

234.29 (3) taxicabs that meet the requirements of this subdivision;

234.30 (4) public transportation, within the meaning of "public transportation" as defined in
234.31 section 174.22, subdivision 7; or

235.1 (5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472,
235.2 subdivision 1, paragraph (p).

235.3 (d) Medical assistance covers nonemergency medical transportation provided by
235.4 nonemergency medical transportation providers enrolled in the Minnesota health care
235.5 programs. All nonemergency medical transportation providers must comply with the
235.6 operating standards for special transportation service as defined in sections 174.29 to 174.30
235.7 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
235.8 commissioner and reported on the claim as the individual who provided the service. All
235.9 nonemergency medical transportation providers shall bill for nonemergency medical
235.10 transportation services in accordance with Minnesota health care programs criteria. Publicly
235.11 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
235.12 requirements outlined in this paragraph. This paragraph expires upon the effective date of
235.13 paragraph (e).

235.14 (e) Effective January 1, 2027, or upon federal approval, whichever is later, medical
235.15 assistance covers nonemergency medical transportation provided by nonemergency medical
235.16 transportation providers enrolled in the Minnesota health care programs. All nonemergency
235.17 medical transportation providers must comply with the operating standards for special
235.18 transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter
235.19 8840, and all drivers must be individually enrolled with the commissioner and reported on
235.20 the claim as the individual who provided the service. All nonemergency medical
235.21 transportation providers shall bill for nonemergency medical transportation services in
235.22 accordance with Minnesota health care programs criteria and comply with the requirements
235.23 of section 256B.073. Publicly operated transit systems, volunteers, and not-for-hire vehicles
235.24 are exempt from the requirements outlined in this paragraph.

235.25 ~~(e)~~ (f) An organization may be terminated, denied, or suspended from enrollment if:

235.26 (1) the provider has not initiated background studies on the individuals specified in
235.27 section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

235.28 (2) the provider has initiated background studies on the individuals specified in section
235.29 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

235.30 (i) the commissioner has sent the provider a notice that the individual has been
235.31 disqualified under section 245C.14; and

235.32 (ii) the individual has not received a disqualification set-aside specific to the special
235.33 transportation services provider under sections 245C.22 and 245C.23.

236.1 ~~(f)~~ (g) The administrative agency of nonemergency medical transportation must:

236.2 (1) adhere to the policies defined by the commissioner;

236.3 (2) pay nonemergency medical transportation providers for services provided to
236.4 Minnesota health care programs beneficiaries to obtain covered medical services;

236.5 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
236.6 trips, and number of trips by mode; and

236.7 (4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single
236.8 administrative structure assessment tool that meets the technical requirements established
236.9 by the commissioner, reconciles trip information with claims being submitted by providers,
236.10 and ensures prompt payment for nonemergency medical transportation services. This
236.11 paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
236.12 for prepaid medical assistance.

236.13 ~~(g)~~ (h) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid
236.14 medical assistance, the administrative agency of nonemergency medical transportation must:

236.15 (1) adhere to the policies defined by the commissioner;

236.16 (2) pay nonemergency medical transportation providers for services provided to
236.17 Minnesota health care program beneficiaries to obtain covered medical services; and

236.18 (3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled
236.19 trips, and number of trips by mode.

236.20 ~~(h)~~ (i) Until the commissioner implements the single administrative structure and delivery
236.21 system under subdivision 18e, clients shall obtain their level-of-service certificate from the
236.22 commissioner or an entity approved by the commissioner that does not dispatch rides for
236.23 clients using modes of transportation under paragraph ~~(h)~~ (o), clauses (4), (5), (6), and (7).
236.24 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,
236.25 2027, for prepaid medical assistance.

236.26 ~~(i)~~ (j) The commissioner may use an order by the recipient's attending physician, advanced
236.27 practice registered nurse, physician assistant, or a medical or mental health professional to
236.28 certify that the recipient requires nonemergency medical transportation services.

236.29 Nonemergency medical transportation providers shall perform driver-assisted services for
236.30 eligible individuals, when appropriate. Driver-assisted service includes passenger pickup
236.31 at and return to the individual's residence or place of business, assistance with admittance
236.32 of the individual to the medical facility, and assistance in passenger securement or in securing
236.33 of wheelchairs, child seats, or stretchers in the vehicle.

237.1 ~~(j)~~ (k) Nonemergency medical transportation providers must take clients to the health
237.2 care provider using the most direct route, and must not exceed 30 miles for a trip to a primary
237.3 care provider or 60 miles for a trip to a specialty care provider, unless the client receives
237.4 authorization from the local agency. This paragraph expires July 1, 2026, for medical
237.5 assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

237.6 ~~(k)~~ (l) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
237.7 for prepaid medical assistance, nonemergency medical transportation providers must take
237.8 clients to the health care provider using the most direct route and must not exceed 30 miles
237.9 for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless
237.10 the client receives authorization from the administrator.

237.11 ~~(l)~~ (m) Nonemergency medical transportation providers may not bill for separate base
237.12 rates for the continuation of a trip beyond the original destination. Nonemergency medical
237.13 transportation providers must maintain trip logs, which include pickup and drop-off times,
237.14 signed by the medical provider or client, whichever is deemed most appropriate, attesting
237.15 to mileage traveled to obtain covered medical services. Clients requesting client mileage
237.16 reimbursement must sign the trip log attesting mileage traveled to obtain covered medical
237.17 services.

237.18 ~~(m)~~ (n) The administrative agency shall use the level of service process established by
237.19 the commissioner to determine the client's most appropriate mode of transportation. If public
237.20 transit or a certified transportation provider is not available to provide the appropriate service
237.21 mode for the client, the client may receive a onetime service upgrade.

237.22 ~~(n)~~ (o) The covered modes of transportation are:

237.23 (1) client reimbursement, which includes client mileage reimbursement provided to
237.24 clients who have their own transportation, or to family or an acquaintance who provides
237.25 transportation to the client;

237.26 (2) volunteer transport, which includes transportation by volunteers using their own
237.27 vehicle;

237.28 (3) unassisted transport, which includes transportation provided to a client by a taxicab
237.29 or public transit. If a taxicab or public transit is not available, the client can receive
237.30 transportation from another nonemergency medical transportation provider;

237.31 (4) assisted transport, which includes transport provided to clients who require assistance
237.32 by a nonemergency medical transportation provider;

238.1 (5) lift-equipped/ramp transport, which includes transport provided to a client who is
238.2 dependent on a device and requires a nonemergency medical transportation provider with
238.3 a vehicle containing a lift or ramp;

238.4 (6) protected transport, which includes transport provided to a client who has received
238.5 a prescreening that has deemed other forms of transportation inappropriate and who requires
238.6 a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety
238.7 locks, a video recorder, and a transparent thermoplastic partition between the passenger and
238.8 the vehicle driver; and (ii) who is certified as a protected transport provider; and

238.9 (7) stretcher transport, which includes transport for a client in a prone or supine position
238.10 and requires a nonemergency medical transportation provider with a vehicle that can transport
238.11 a client in a prone or supine position.

238.12 ~~(p)~~ (p) The local agency shall be the single administrative agency and shall administer
238.13 and reimburse for modes defined in paragraph ~~(n)~~ (o) according to paragraphs ~~(r)~~ (s) to ~~(t)~~
238.14 (u) when the commissioner has developed, made available, and funded the web-based single
238.15 administrative structure, assessment tool, and level of need assessment under subdivision
238.16 18e. The local agency's financial obligation is limited to funds provided by the state or
238.17 federal government. This paragraph expires July 1, 2026, for medical assistance
238.18 fee-for-service and January 1, 2027, for prepaid medical assistance.

238.19 ~~(p)~~ (q) The commissioner shall:

238.20 (1) verify that the mode and use of nonemergency medical transportation is appropriate;

238.21 (2) verify that the client is going to an approved medical appointment; and

238.22 (3) investigate all complaints and appeals.

238.23 ~~(q)~~ (r) The administrative agency shall pay for the services provided in this subdivision
238.24 and seek reimbursement from the commissioner, if appropriate. As vendors of medical care,
238.25 local agencies are subject to the provisions in section 256B.041, the sanctions and monetary
238.26 recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245.
238.27 This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1,
238.28 2027, for prepaid medical assistance.

238.29 ~~(r)~~ (s) Payments for nonemergency medical transportation must be paid based on the
238.30 client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle used to provide the
238.31 service. The medical assistance reimbursement rates for nonemergency medical transportation
238.32 services that are payable by or on behalf of the commissioner for nonemergency medical
238.33 transportation services are:

- 239.1 (1) \$0.22 per mile for client reimbursement;
- 239.2 (2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer
239.3 transport;
- 239.4 (3) equivalent to the standard fare for unassisted transport when provided by public
239.5 transit, and \$12.10 for the base rate and \$1.43 per mile when provided by a nonemergency
239.6 medical transportation provider;
- 239.7 (4) \$14.30 for the base rate and \$1.43 per mile for assisted transport;
- 239.8 (5) \$19.80 for the base rate and \$1.70 per mile for lift-equipped/ramp transport;
- 239.9 (6) \$75 for the base rate and \$2.40 per mile for protected transport; and
- 239.10 (7) \$60 for the base rate and \$2.40 per mile for stretcher transport, and \$9 per trip for
239.11 an additional attendant if deemed medically necessary. This paragraph expires July 1, 2026,
239.12 for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.
- 239.13 ~~(s)~~ (t) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
239.14 for prepaid medical assistance, payments for nonemergency medical transportation must
239.15 be paid based on the client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle
239.16 used to provide the service.
- 239.17 ~~(t)~~ (u) The base rate for nonemergency medical transportation services in areas defined
239.18 under RUCA to be super rural is equal to 111.3 percent of the respective base rate in
239.19 paragraph ~~(t)~~ (s), clauses (1) to (7). The mileage rate for nonemergency medical transportation
239.20 services in areas defined under RUCA to be rural or super rural areas is:
- 239.21 (1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage
239.22 rate in paragraph ~~(t)~~ (s), clauses (1) to (7); and
- 239.23 (2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage
239.24 rate in paragraph ~~(t)~~ (s), clauses (1) to (7). This paragraph expires July 1, 2026, for medical
239.25 assistance fee-for-service and January 1, 2027, for prepaid medical assistance.
- 239.26 ~~(u)~~ (v) For purposes of reimbursement rates for nonemergency medical transportation
239.27 services under paragraphs ~~(t)~~ (s) to ~~(t)~~ (u), the zip code of the recipient's place of residence
239.28 shall determine whether the urban, rural, or super rural reimbursement rate applies. This
239.29 paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
239.30 for prepaid medical assistance.

240.1 ~~(v)~~ (w) The commissioner, when determining reimbursement rates for nonemergency
240.2 medical transportation, shall exempt all modes of transportation listed under paragraph ~~(n)~~
240.3 (o) from Minnesota Rules, part 9505.0445, item R, subitem (2).

240.4 ~~(w)~~ (x) Effective for the first day of each calendar quarter in which the price of gasoline
240.5 as posted publicly by the United States Energy Information Administration exceeds \$3.00
240.6 per gallon, the commissioner shall adjust the rate paid per mile in paragraph ~~(r)~~ (s) by one
240.7 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
240.8 increase or decrease must be calculated using a base gasoline price of \$3.00. The percentage
240.9 increase or decrease must be calculated using the average of the most recently available
240.10 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
240.11 Information Administration. This paragraph expires July 1, 2026, for medical assistance
240.12 fee-for-service and January 1, 2027, for prepaid medical assistance.

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

240.14 Sec. 5. Minnesota Statutes 2024, section 256B.0625, subdivision 17b, is amended to read:

240.15 Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency
240.16 medical transportation providers must document each occurrence of a service provided to
240.17 a recipient according to this subdivision. Providers must maintain records sufficient to
240.18 distinguish individual trips with specific vehicles and drivers. The documentation may be
240.19 collected and maintained using electronic systems or software or in paper form but must be
240.20 made available and produced upon request. Program funds paid for transportation that is
240.21 not documented according to this subdivision may be subject to recovery by the commissioner
240.22 pursuant to section 256B.064.

240.23 (b) A nonemergency medical transportation provider must compile transportation trip
240.24 records that are written in English and legible according to the standard of a reasonable
240.25 person and that include each of the following elements:

240.26 (1) the recipient's name;

240.27 (2) the date or dates the service is provided, if different than the date the entry was made;

240.28 (3) either the printed name of the driver sufficient to distinguish the driver of service or
240.29 the driver's provider number;

240.30 (4) the date and the signature of the driver attesting that the record accurately represents
240.31 the services provided and the actual miles driven, and acknowledging that misreporting
240.32 information that results in ineligible or excessive payments may result in civil or criminal
240.33 action;

241.1 (5) the date and the signature of the recipient or authorized party attesting that
241.2 transportation services were provided as indicated on the transportation trip record, or the
241.3 signature of the medical services provider certifying that the recipient was transported to
241.4 the medical services provider destination. In the event that both the medical services provider
241.5 and the recipient or authorized party refuse or are unable to provide signatures, the driver
241.6 must document on the transportation trip record that signatures were requested and not
241.7 provided;

241.8 (6) the address, or the description if the address is not available, of both the origin and
241.9 destination, and the mileage for the most direct route from the origin to the destination;

241.10 (7) the name or number of the mode of transportation in which the service is provided;

241.11 (8) the license plate number of the vehicle used to transport the recipient;

241.12 (9) the time of the recipient pickup;

241.13 (10) the time of the recipient drop-off;

241.14 (11) the odometer reading of the vehicle used to transport the recipient taken at the time
241.15 of pickup;

241.16 (12) the odometer reading of the vehicle used to transport the recipient taken at the time
241.17 of drop-off;

241.18 (13) the name of the extra attendant when an extra attendant is used to provide special
241.19 transportation service; and

241.20 (14) the documentation indicating the method that was used to determine the most direct
241.21 route.

241.22 (c) In determining whether the commissioner will seek recovery, the documentation
241.23 requirements in this section apply retroactively to audit findings beginning January 1, 2020,
241.24 and to all audit findings thereafter.

241.25 (d) Effective January 1, 2027, or upon federal approval, whichever is later, records that
241.26 comply with section 256B.073 may be used to meet the requirements of this subdivision if
241.27 all required elements are included in the record.

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

241.29 Sec. 6. Minnesota Statutes 2024, section 256B.073, subdivision 1, is amended to read:

241.30 Subdivision 1. **Documentation; establishment and operation.** The commissioner of
241.31 human services shall establish ~~implementation requirements and standards for~~ and maintain

242.1 the requirements and standards for the ongoing operation of electronic visit verification to
242.2 comply with the 21st Century Cures Act, Public Law 114-255. Within available
242.3 appropriations, the commissioner shall take steps to comply with the electronic visit
242.4 verification requirements in the 21st Century Cures Act, Public Law 114-255.

242.5 Sec. 7. Minnesota Statutes 2024, section 256B.073, subdivision 2, is amended to read:

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

242.8 (b) "Data aggregator" means the entity designated by the commissioner to collect, store,
242.9 and transmit electronic visit verification data from providers and third-party systems to the
242.10 commissioner in accordance with the standards and requirements established under this
242.11 section.

242.12 ~~(b)~~ (c) "Electronic visit verification" or "EVV" means the electronic documentation of
242.13 the process required under United States Code, title 42, section 1396b(1), and this section
242.14 used to electronically verify:

242.15 (1) type of service performed;

242.16 (2) individual receiving the service;

242.17 (3) date of the service;

242.18 (4) location of the service delivery;

242.19 (5) individual providing the service; and

242.20 (6) time the service begins and ends.

242.21 (d) "Electronic visit verification data" means information collected through an electronic
242.22 visit verification system, including data elements required under United States Code, title
242.23 42, section 1396b(1), and any additional data elements specified by the commissioner under
242.24 this section.

242.25 ~~(e)~~ (e) "Electronic visit verification system" means a system that provides electronic
242.26 verification of services used to collect, verify, and transmit EVV data to the commissioner
242.27 or the commissioner's designated data aggregator that complies with the 21st Century Cures
242.28 Act, Public Law 114-255, and the requirements of subdivision 3.

242.29 (f) "Electronic visit verification vendor" means any entity that develops, provides, or
242.30 supports an electronic visit verification system, including the state-provided vendor and
242.31 any third-party vendor.

243.1 (g) "Financial management services provider" means an entity enrolled with the
 243.2 commissioner to provide financial management services under section 256B.85 or other
 243.3 applicable law and responsible for fiscal, payroll, and reporting functions on behalf of
 243.4 participant employers.

243.5 (h) "Individual" means a person who receives services subject to electronic visit
 243.6 verification under the medical assistance program.

243.7 (i) "Managed care organization" means a public or private organization that contracts
 243.8 with the commissioner under section 256B.69 or other applicable law to deliver health care
 243.9 services to individuals eligible for medical assistance or MinnesotaCare.

243.10 (j) "Provider" means an individual or organization that meets one or more of the following
 243.11 conditions:

243.12 (1) is enrolled as a Minnesota health care programs provider;

243.13 (2) provides services through a managed care organization under contract with the
 243.14 commissioner under section 256B.69;

243.15 (3) is a financial management services provider; or

243.16 (4) is a participant employer under section 256B.85, subdivision 7, or an employer of
 243.17 record directing services under section 256B.49, subdivision 16.

243.18 ~~(d)~~ (k) "Service" means one of the following:

243.19 (1) personal care assistance services as defined in section 256B.0625, subdivision 19a,
 243.20 and provided according to section 256B.0659;

243.21 (2) community first services and supports under section 256B.85;

243.22 (3) home health services under section 256B.0625, subdivision 6a; or

243.23 (4) all unit-based services delivered by a provider that is a provider type designated
 243.24 high-risk by the commissioner based on the criteria and standards used to designate Medicare
 243.25 providers in Code of Federal Regulations, title 42, section 424.518;

243.26 (5) unit-based services that are designated high-risk by the commissioner; or

243.27 ~~(4)~~ (6) other medical supplies and equipment or home and community-based services
 243.28 that are required to be electronically verified by the 21st Century Cures Act, Public Law
 243.29 114-255.

244.1 (l) "State-provided electronic visit verification system" means the electronic visit
 244.2 verification system made available by the commissioner to providers at no cost for services
 244.3 subject to federal electronic visit verification requirements.

244.4 (m) "Third-party electronic visit verification system" means an electronic visit verification
 244.5 system purchased or operated by a provider or vendor other than the state-provided system
 244.6 designated by the commissioner.

244.7 (n) "Verification method" means the electronic process used to capture and verify visit
 244.8 information, including telephone, fixed visit verification devices, or mobile applications,
 244.9 as approved by the commissioner.

244.10 (o) "Visit" means a single occurrence of service delivery subject to electronic visit
 244.11 verification.

244.12 (p) "Worker" means an individual who provides personal care assistance services,
 244.13 community first services and supports, home health services, consumer-directed community
 244.14 supports, or other services identified by the commissioner as subject to electronic visit
 244.15 verification.

244.16 Sec. 8. Minnesota Statutes 2024, section 256B.073, subdivision 3, is amended to read:

244.17 Subd. 3. **Requirements.** (a) ~~In developing implementation requirements for administering~~
 244.18 ~~electronic visit verification, the commissioner shall~~ must ensure that the system and related
 244.19 requirements:

244.20 (1) ~~are minimally~~ administratively and financially burdensome to a provider reasonable
 244.21 for providers;

244.22 (2) ~~are minimally burdensome~~ support continued access to the services and are designed
 244.23 to avoid disruption to service recipient and the least disruptive to the service recipient in
 244.24 ~~receiving and maintaining allowed services~~ delivery or receipt;

244.25 (3) consider existing best practices and use of electronic visit verification;

244.26 (4) are conducted according to all state and federal laws;

244.27 (5) are effective methods for preventing fraud when balanced against the requirements
 244.28 of clauses (1) and (2); and

244.29 (6) are consistent with the Department of Human Services' policies related to covered
 244.30 services, flexibility of service use, and quality assurance.

245.1 (b) The commissioner ~~shall~~ must make training and guidance available to providers on
245.2 the electronic visit verification ~~system~~ requirements and system use.

245.3 (c) The commissioner ~~shall~~ must establish baseline measurements related to preventing
245.4 fraud and establish measures to determine the effect of electronic visit verification
245.5 requirements on program integrity.

245.6 (d) The commissioner ~~shall~~ must make a state-selected electronic visit verification system
245.7 available to providers of services.

245.8 (e) The commissioner ~~shall~~ must make available and publish on the agency website the
245.9 name and contact information for the vendor of the state-selected electronic visit verification
245.10 system and the other vendors that offer alternative electronic visit verification systems. The
245.11 information provided must state that the state-selected electronic visit verification system
245.12 is offered at no cost to the provider of services and that the provider may choose an alternative
245.13 system that may be at a cost to the provider.

245.14 (f) The commissioner may establish implementation dates and implementation schedules
245.15 for services or system functions subject to electronic visit verification under this section,
245.16 including but not limited to the phased addition of new services, verification methods, or
245.17 technical requirements.

245.18 (g) The commissioner may waive the requirements of this section for any service
245.19 component or setting when the application of electronic visit verification is contrary to
245.20 paragraph (a).

245.21 Sec. 9. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
245.22 to read:

245.23 Subd. 4a. **Electronic visit verification system options.** (a) A provider must use an
245.24 electronic visit verification system that complies with the requirements established by the
245.25 commissioner. A provider may use either the state-provided system or a third-party system.
245.26 All systems used for compliance must provide data to the commissioner in the format and
245.27 frequency required by the commissioner.

245.28 (b) The commissioner must make a state-provided electronic visit verification system
245.29 available at no cost to providers of services. The commissioner must provide training on
245.30 the system to all providers.

245.31 (c) The commissioner must allow providers of services to utilize a third-party electronic
245.32 visit verification system that the commissioner determines meets the requirements of this
245.33 section.

246.1 (d) A provider using a third-party electronic visit verification system that meets all
246.2 technical specifications and federal and state laws must:

246.3 (1) collect and submit all data for each visit to the commissioner, including but not
246.4 limited to manual entries;

246.5 (2) maintain compliance identified by the commissioner, including but not limited to
246.6 incorporating into the system any changes in data requirements that must be transmitted to
246.7 the state EVV system; and

246.8 (3) integrate the system with the state's designated data aggregator to accurately send
246.9 data.

246.10 (e) The state-designated data aggregator must be available at no cost to a provider for
246.11 purposes of transmitting electronic visit verification data from approved third-party systems
246.12 to the commissioner. Any costs associated with the development and use of a third-party
246.13 system are the responsibility of the provider.

246.14 (f) If a provider is unable to integrate a third-party system with the designated state
246.15 aggregator, the provider must use the state EVV system.

246.16 (g) The commissioner must provide training on reviewing and correcting imported data
246.17 in the state's designated data aggregator to providers.

246.18 Sec. 10. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
246.19 to read:

246.20 Subd. 4b. **Provider responsibilities.** A provider must:

246.21 (1) use an electronic visit verification system that meets all technical and data submission
246.22 requirements established by the commissioner;

246.23 (2) enroll with the state-provided electronic visit verification system or the commissioner's
246.24 designated data aggregator, as applicable;

246.25 (3) provide all information requested by the commissioner for enrollment, access, and
246.26 data submission and ensure that such information remains accurate and up to date;

246.27 (4) maintain records for each individual receiving services subject to electronic visit
246.28 verification, including but not limited to all required data elements;

246.29 (5) maintain a current list of workers providing services subject to electronic visit
246.30 verification to individuals receiving services under medical assistance;

247.1 (6) provide the commissioner and any managed care organization under contract with
247.2 the commissioner under section 256B.69 with immediate, direct, and on-site or remote
247.3 access to the electronic visit verification system;

247.4 (7) at the request of the commissioner or a managed care organization, allow review or
247.5 copying of electronic visit verification documentation at no cost;

247.6 (8) ensure that electronic visit verification systems and related processes meet accessibility
247.7 and confidentiality requirements under state and federal law;

247.8 (9) comply with all policies, procedures, and technical specifications issued by the
247.9 commissioner under this section; and

247.10 (10) ensure that workers, participants, and other individuals using electronic visit
247.11 verification are trained and comply with all documentation and data entry requirements
247.12 established by the commissioner.

247.13 Sec. 11. Minnesota Statutes 2024, section 256B.073, subdivision 5, is amended to read:

247.14 Subd. 5. **Vendor requirements.** (a) The vendor of the electronic visit verification system
247.15 selected by the commissioner and the vendor's affiliate must comply with the requirements
247.16 of this subdivision.

247.17 (b) The vendor of the ~~state-selected~~ state-provided electronic visit verification system
247.18 and the vendor's affiliate must:

247.19 (1) notify the provider of services that the provider may choose the ~~state-selected~~
247.20 state-provided electronic visit verification system at no cost to the provider;

247.21 (2) offer the ~~state-selected~~ state-provided electronic visit verification system to the
247.22 provider of services prior to offering any fee-based electronic visit verification system;

247.23 (3) notify the provider of services that the provider may choose any fee-based electronic
247.24 visit verification system prior to offering the vendor's or its affiliate's fee-based electronic
247.25 visit verification system; and

247.26 (4) when offering the ~~state-selected~~ state-provided electronic visit verification system,
247.27 clearly differentiate between the ~~state-selected~~ state-provided electronic visit verification
247.28 system and the vendor's or its affiliate's alternative fee-based system.

247.29 (c) The vendor of the ~~state-selected~~ state-provided electronic visit verification system
247.30 and the vendor's affiliate must not use state data that are not available to other vendors of
247.31 electronic visit verification systems to promote or sell the vendor's or its affiliate's alternative
247.32 electronic visit verification system.

248.1 (d) Upon request from the provider, the vendor of the ~~state-selected~~ state-provided
248.2 electronic visit verification system must provide proof of compliance with the requirements
248.3 of paragraph (b).

248.4 (e) An agreement between the vendor of the ~~state-selected~~ state-provided electronic visit
248.5 verification system or its affiliate and a provider of services for an electronic visit verification
248.6 system that is not the ~~state-selected~~ state-provided system entered into on or after July 1,
248.7 2023, is subject to immediate termination by the provider if the vendor violates any of the
248.8 requirements of paragraph (b).

248.9 Sec. 12. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
248.10 to read:

248.11 Subd. 6. Data and documentation. (a) A provider must submit electronic visit
248.12 verification data to the commissioner or the commissioner's designated data aggregator in
248.13 accordance with the technical standards, format, and frequency established under this section.
248.14 The commissioner may use integrated electronic visit verification data for oversight, quality
248.15 assurance, and program integrity purposes consistent with state and federal law.

248.16 (b) The commissioner and managed care organizations must use electronic visit
248.17 verification data to validate claims for payment under medical assistance. Claims that cannot
248.18 be validated in accordance with electronic visit verification requirements may be subject
248.19 to actions by the commissioner as authorized under state and federal law, including actions
248.20 related to payment, program integrity, or provider compliance.

248.21 (c) A provider must record all required electronic visit verification data at the time of
248.22 service delivery using an approved verification method. To be compliant with electronic
248.23 visit verification requirements, a provider must document a visit with all required data
248.24 elements recorded at the time of service delivery.

248.25 (d) A manual visit is a visit:

248.26 (1) entered administratively and not by the caregiver at the time of service delivery; or

248.27 (2) where data elements are edited after the time of service delivery.

248.28 (e) A manual visit does not comply with electronic visit verification requirements. A
248.29 manual visit must be confirmed and verified according to processes established by the
248.30 commissioner before being used to validate or support a claim for payment.

248.31 (f) A worker providing services subject to electronic visit verification must record the
248.32 start and end times of each visit at the time the service is delivered using an approved

249.1 verification method. A worker must complete and verify all time documentation, including
249.2 but not limited to verification of service type, date, and duration, on the date the service
249.3 occurs and be consistent with documentation requirements under sections 256B.0625,
249.4 subdivision 6a; 256B.0659, subdivision 12; 256B.49, subdivision 16; and 256B.85,
249.5 subdivision 15. A provider of services must maintain documentation demonstrating
249.6 compliance with this subdivision and make the documentation available to the commissioner
249.7 or a managed care organization under contract with the commissioner under section 256B.69
249.8 upon request.

249.9 Sec. 13. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
249.10 to read:

249.11 Subd. 7. **Third-party system responsibilities.** (a) This section is effective for Early
249.12 Intensive Developmental and Behavioral Intervention services beginning July 1, 2027, or
249.13 upon federal approval, whichever is later. This section is effective for all other services
249.14 subject to this subdivision beginning January 1, 2027, or upon federal approval, whichever
249.15 is later.

249.16 (b) A provider that uses a third-party electronic visit verification system must ensure
249.17 that the system meets all technical, functional, and data-exchange requirements established
249.18 by the commissioner and transmits data to the commissioner or the commissioner's designated
249.19 data aggregator in the format and frequency required by the commissioner.

249.20 (c) A third-party electronic visit verification vendor must:

249.21 (1) comply with all technical, contractual, privacy, and security standards established
249.22 by the commissioner;

249.23 (2) not use or disclose state data for any purpose other than fulfilling the requirements
249.24 of this section or federal law;

249.25 (3) provide the commissioner access to system documentation, data mapping, and audit
249.26 records upon request; and

249.27 (4) immediately report to the commissioner any data transmission failure, breach, or
249.28 interruption affecting the state's ability to receive required electronic visit verification data.

249.29 (d) A provider remains responsible for ensuring compliance with this section even when
249.30 using a third-party electronic visit verification system.

249.31 (e) The third-party vendor must ensure training on the system is available to providers.

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

250.1 Sec. 14. Minnesota Statutes 2025 Supplement, section 256B.0911, subdivision 14, is
250.2 amended to read:

250.3 Subd. 14. **Use of MnCHOICES certified assessors required.** (a) Each lead agency
250.4 shall use MnCHOICES certified assessors who have completed MnCHOICES training and
250.5 the certification process determined by the commissioner in subdivision 13.

250.6 (b) Each lead agency must ensure that the lead agency has sufficient numbers of certified
250.7 assessors to provide long-term consultation assessment and support planning within the
250.8 timelines and parameters of the service.

250.9 (c) A lead agency may choose, according to departmental policies, to contract with a
250.10 qualified, certified assessor to conduct assessments and reassessments on behalf of the lead
250.11 agency.

250.12 (d) Tribes and health plans under contract with the commissioner must provide long-term
250.13 care consultation services as specified in the contract.

250.14 (e) A lead agency must provide the commissioner with an administrative contact for
250.15 communication purposes.

250.16 (f) A lead agency may contract under this subdivision with any hospital licensed under
250.17 sections 144.50 to 144.56 to conduct assessments of patients in the hospital on behalf of
250.18 the lead agency when the lead agency has failed to meet its obligations under subdivision
250.19 17. The contracted assessment must be conducted by a hospital employee who is a qualified,
250.20 certified assessor. The hospital employees who perform assessments under the contract
250.21 between the hospital and the lead agency may perform assessments in addition to other
250.22 duties assigned to the employee by the hospital, except the hospital employees who perform
250.23 the assessments under contract with the lead agency must not perform any waiver-related
250.24 tasks other than assessments. Hospitals are not eligible for reimbursement under subdivision
250.25 33. The lead agency that enters into a contract with a hospital under this paragraph is
250.26 responsible for oversight, compliance, and quality assurance for all assessments performed
250.27 under the contract.

250.28 (g) The commissioner must employ certified assessors within the department to conduct
250.29 assessments on behalf of lead agencies under conditions and circumstances determined by
250.30 the commissioner. Certified assessors employed by the department may conduct assessments
250.31 in addition to other duties as assigned, except the certified assessors employed by the
250.32 department must not perform any responsibilities of a lead agency described in this section
250.33 other than assessments. Nothing in this paragraph creates an obligation for the department

251.1 to provide the department's certified assessors to conduct assessments on behalf of a lead
251.2 agency.

251.3 Sec. 15. Minnesota Statutes 2024, section 256B.0911, subdivision 32, is amended to read:

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

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

251.7 (2) provide the services in this section; ~~and~~

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

251.11 (4) grant limited role-based access to a person's support plan in the MnCHOICES system
251.12 to home and community-based service providers who have been designated as a provider
251.13 for that person by a lead agency for the purpose of signing the person's support plan
251.14 electronically and demonstrating that the provider has reviewed, understood, and agrees to
251.15 deliver services as outlined in the plan.

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

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

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

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

251.27 Sec. 16. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision
251.28 to read:

251.29 Subd. 19. **Billing limits.** (a) Effective July 1, 2027, or upon federal approval, whichever
251.30 is later, the following billing limits apply to early intensive developmental and behavioral
251.31 intervention services:

252.1 (1) intensive services: 40 hours per week per recipient;

252.2 (2) travel: two hours per day per recipient;

252.3 (3) observation and direction: 20 hours per week per recipient; and

252.4 (4) individual treatment and planning: 300 units per year per recipient.

252.5 (b) The commissioner must grant exceptions to the billing limits under paragraph (a)

252.6 when services in excess of the billing limits are determined to be medically necessary. A

252.7 provider must apply to the commissioner for an exception on the forms and in the manner

252.8 prescribed by the commissioner. A determination under this paragraph is final and not

252.9 subject to appeal.

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

252.11 Sec. 17. Minnesota Statutes 2024, section 256B.4905, subdivision 11, is amended to read:

252.12 Subd. 11. **Informed choice in technology policy.** It is the policy of this state that all

252.13 adults who have disabilities and children who have disabilities:

252.14 (1) can use assistive technology, remote supports, or a combination of both to enhance

252.15 the adult's or child's independence and quality of life; and

252.16 (2) have the right, at least annually, to make an informed choice about the adult's or

252.17 child's use of assistive technology and remote supports when permitted under the individual's

252.18 federally approved waiver plan, service authorization, and applicable service standards.

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

252.20 Sec. 18. Minnesota Statutes 2024, section 256B.4905, subdivision 12, is amended to read:

252.21 Subd. 12. **Informed choice and technology prioritization in implementation for**

252.22 **disability waiver services.** (a) The commissioner of human services shall ensure that:

252.23 (1) disability waivers under sections 256B.092 and 256B.49 support the presumption

252.24 that all adults who have disabilities and children who have disabilities may use assistive

252.25 technology, remote supports, or both to enhance the adult's or child's independence and

252.26 quality of life; ~~and~~

252.27 (2) each individual accessing waiver services is offered, after an informed

252.28 decision-making process and during a person-centered planning process, the opportunity

252.29 to choose assistive technology, remote support, or both prior to the commissioner offering

252.30 or reauthorizing services that utilize direct support staff to ensure equitable access; and

253.1 (3) policies and procedures related to the use of technology, including but not limited
253.2 to remote support, promote informed choice and protect the health and safety of individuals
253.3 receiving services consistent with federal law and the terms of approved waiver plans.

253.4 (b) Nothing in this subdivision authorizes the use of remote support as a method of
253.5 service delivery unless expressly permitted under the applicable service definition, waiver
253.6 plan, and service standards approved by the Centers for Medicare and Medicaid Services.

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

253.8 Sec. 19. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision
253.9 to read:

253.10 Subd. 17. **Billing limits.** (a) The limits in this subdivision establish the maximum amounts
253.11 of authorized units for each service within a service day, week, or month.

253.12 (b) Effective January 1, 2027, or upon federal approval, whichever is later, the following
253.13 billing limits apply:

253.14 (1) adult companion services: up to six hours per day per recipient with a maximum of
253.15 963 hours annually;

253.16 (2) chore services: up to six hours per week per recipient for 15-minute units;

253.17 (3) homemaker services, cleaning: up to 16 hours per week per recipient;

253.18 (4) homemaker services, home management: up to 16 hours per week per recipient;

253.19 (5) day support services: up to eight hours per day per recipient;

253.20 (6) family training and counseling under a disability waiver: up to two hours per week
253.21 per recipient or family unit;

253.22 (7) community residential services one-to-one staffing: the maximum daily hours
253.23 permitted under the applicable service tier under section 256B.4914, as published by the
253.24 commissioner;

253.25 (8) independent living skills: up to six hours per day per recipient;

253.26 (9) home-delivered meals: up to two meals per day per recipient;

253.27 (10) individualized home supports: up to 16 hours per day per recipient, inclusive of all
253.28 staffing ratios;

253.29 (11) personal emergency response system: one unit per month per recipient, inclusive
253.30 of installation, monitoring, and maintenance;

254.1 (12) respite services provided in the recipient's home: 30 consecutive days per occurrence;

254.2 (13) night supervision services: ten hours per day per recipient, with no more than eight

254.3 hours asleep; and

254.4 (14) transportation services: 28 one-way trips per week per participant.

254.5 (c) For personal emergency response system billing units under paragraph (b), clause

254.6 (11), lead agency staff must end service lines for any inactive providers to prevent duplicate

254.7 billing.

254.8 (d) The limits in this subdivision do not limit a person's use of other waiver services.

254.9 Billing limits under this subdivision apply only to the individual service listed and do not

254.10 prohibit the recipient from accessing other services for which they are eligible on the same

254.11 day, week, or month, subject to other applicable requirements.

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

254.13 Sec. 20. Minnesota Statutes 2024, section 256B.4914, subdivision 6d, is amended to read:

254.14 Subd. 6d. **Payment for customized living.** (a) The payment methodology for customized

254.15 living and 24-hour customized living must be the customized living tool. The commissioner

254.16 shall revise the customized living tool to reflect the services and activities unique to

254.17 disability-related recipient needs and adjust for regional differences in the cost of providing

254.18 services.

254.19 (b) The rate adjustments described in section 256S.205 do not apply to rates paid under

254.20 this section.

254.21 (c) Customized living and 24-hour customized living rates determined under this section

254.22 shall not include more than 24 hours of support in a daily unit.

254.23 (d) The commissioner shall establish the following acuity-based customized living tool

254.24 input limits, based on case mix, for customized living and 24-hour customized living rates

254.25 determined under this section:

254.26 (1) no more than two hours of mental health management per day for people assessed

254.27 for case mixes A, D, and G;

254.28 (2) no more than four hours of activities of daily living assistance per day for people

254.29 assessed for case mix B; and

254.30 (3) no more than six hours of activities of daily living assistance per day for people

254.31 assessed for case mix D.

255.1 (e) Customized living monthly service rate limits must align with monthly service rate
255.2 limits determined under section 256S.202, subdivisions 1 and 2.

255.3 Sec. 21. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 8, is
255.4 amended to read:

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

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

255.12 (1) competitive workforce factor: 6.7 percent;

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

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

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

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

255.17 (6) client programming and support ratio: 4.7 percent, updated as specified in subdivision
255.18 5b;

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

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

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

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

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

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

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

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

- 256.1 (4) for a recipient requiring customization for deaf and hard-of-hearing language
256.2 accessibility under subdivision 12, add the customization rate provided in subdivision 12
256.3 to the result of clause (3);
- 256.4 (5) multiply the number of direct staffing hours by the appropriate staff wage;
- 256.5 (6) multiply the number of direct staffing hours by the product of the supervisory span
256.6 of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);
- 256.7 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
256.8 employee vacation, sick, and training allowance ratio. This is defined as the direct staffing
256.9 rate;
- 256.10 (8) for program plan support, multiply the result of clause (7) by one plus the program
256.11 plan support ratio;
- 256.12 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
256.13 employee-related cost ratio;
- 256.14 (10) for client programming and supports, multiply the result of clause (9) by one plus
256.15 the client programming and support ratio;
- 256.16 (11) this is the subtotal rate;
- 256.17 (12) sum the standard general administrative support ratio, the program-related expense
256.18 ratio, and the absence and utilization factor ratio;
- 256.19 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
256.20 total payment amount;
- 256.21 (14) for services provided in a shared manner, divide the total payment in clause (13)
256.22 as follows:
- 256.23 (i) for employment exploration services, divide by the number of service recipients, not
256.24 to exceed five;
- 256.25 (ii) for employment support services, divide by the number of service recipients, not to
256.26 exceed six;
- 256.27 (iii) for individualized home supports with training and individualized home supports
256.28 with family training, divide by the number of service recipients, not to exceed three; and
- 256.29 (iv) for night supervision, divide by the number of service recipients, not to exceed two;
256.30 and

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

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

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

257.13 (1) for individualized home supports with training, a monthly service limit of 182.5
257.14 hours; and

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

257.17 (g) The limits in paragraph (f), clauses (1) and (2), do not limit a person's use of other
257.18 disability waiver services, including individualized home supports, which may be provided
257.19 on the same day by the same provider providing individualized home supports with training
257.20 or individualized home supports with family training or apply to individuals who meet the
257.21 residential support services criteria under sections 256B.092, subdivision 11a, and 256B.49,
257.22 subdivision 29.

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

257.24 Sec. 22. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision
257.25 to read:

257.26 Subd. 10e. **Documentation of staffing; auditing and rate review.** (a) Effective for
257.27 services provided on or after January 1, 2029, a provider enrolled to provide residential
257.28 support services under subdivision 6 must maintain documentation of direct staffing hours
257.29 provided to each person receiving services, including but not limited to documentation
257.30 identifying:

257.31 (1) the name, role, and unique identifier for each staff person who provided services to
257.32 match records to payroll, time and attendance systems, and any other source documentation;

258.1 (2) the date services were provided;

258.2 (3) the total number of hours of direct support provided;

258.3 (4) awake overnight staffing hours provided, if applicable;

258.4 (5) asleep overnight staffing hours provided, if applicable; and

258.5 (6) any other staffing information required by the commissioner.

258.6 (b) A provider must maintain documentation in a manner and format determined by the
258.7 commissioner for at least six years. If a provider changes payroll vendors, merges operations,
258.8 or changes staffing identifiers, the provider must maintain a documented link between prior
258.9 and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and
258.10 role classification for each staff person.

258.11 (c) A provider must submit the documentation required under paragraph (a) to the
258.12 commissioner annually, in a manner and format determined by the commissioner. The
258.13 commissioner must establish multiple submission windows throughout the calendar year
258.14 and may assign providers to a submission window for administrative efficiency and system
258.15 capacity. Documentation must reflect staffing provided during the prior calendar year and
258.16 must be submitted no later than the final business day of the provider's assigned submission
258.17 window. The commissioner may conduct random or targeted validations and audits of
258.18 submitted data and may require supplemental documentation as necessary to verify accuracy
258.19 and compliance.

258.20 (d) The commissioner must conduct periodic analysis of documentation submitted under
258.21 this subdivision and may validate staffing data through random audits or other verification
258.22 methods.

258.23 (e) Based on the analysis under paragraph (d), the commissioner may provide
258.24 recommendations to lead agencies regarding modifications to the rate of a person receiving
258.25 services, including increases or decreases necessary to align the rate with staffing provided
258.26 to the person as demonstrated by the submitted historical staffing documentation.
258.27 Recommendations must be based on the requirements of this section and applicable federal
258.28 and state requirements governing rate setting.

258.29 (f) If a provider fails to submit documentation requested within the submission window
258.30 in paragraph (c), the commissioner must issue a written notice of noncompliance. If
258.31 documentation is not received within 60 days following the notice of noncompliance, the
258.32 commissioner may temporarily suspend payments to the provider until the required
258.33 documentation is submitted. The commissioner must make withheld payments to the provider

259.1 once the required documentation is received. If the noncompliance persists, the commissioner
259.2 may adjust future rate payments, require the provider to submit a corrective action plan, or
259.3 pursue other enforcement actions as authorized by law.

259.4 (g) The commissioner must publish annual aggregate reports summarizing audit findings
259.5 and trends related to staffing provided under this section.

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

259.7 Sec. 23. Minnesota Statutes 2024, section 256B.492, is amended by adding a subdivision
259.8 to read:

259.9 **Subd. 4. Integrated community supports setting approval moratorium and**

259.10 **exception.** (a) For purposes of this subdivision, "integrated community supports setting"

259.11 means a multifamily housing building where a provider delivers integrated community

259.12 supports under section 245D.03, subdivision 1, paragraph (c), clause (8), and for which a

259.13 provider has a provider-controlled or provider-associated financial interest as defined under

259.14 section 245A.02, subdivision 10b.

259.15 (b) The commissioner must not approve a new integrated community supports setting

259.16 or approve an expansion of an existing integrated community supports setting except as

259.17 provided in this subdivision.

259.18 (c) The commissioner may approve an exception to the moratorium only when the

259.19 applicant demonstrates indirect control of the setting and compliance with:

259.20 (1) the federal home and community-based services requirements under Code of Federal

259.21 Regulations, title 42, section 441.301(c);

259.22 (2) the prohibition on the use of medical assistance money for room and board under

259.23 United States Code, title 42, section 1396n(c);

259.24 (3) independent lease requirements consistent with chapter 504B; and

259.25 (4) all documentation requirements under section 245D.12.

259.26 (d) To approve an exception, the commissioner must determine that the lead agency has

259.27 requested the additional capacity to meet the specific disability-related needs of the person.

259.28 Priority must be given to geographic regions with insufficient integrated community supports

259.29 capacity based on statewide or regional needs determination processes.

259.30 (e) A determination under this subdivision is final and not subject to appeal.

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

260.1 Sec. 24. Minnesota Statutes 2024, section 256S.20, is amended by adding a subdivision
260.2 to read:

260.3 Subd. 6. Customized living and 24-hour customized living moratorium. (a) Except
260.4 as permitted in this subdivision, the commissioner must not authorize:

260.5 (1) a new customized living setting or 24-hour customized living setting; or

260.6 (2) a new provider enrollment to deliver customized living services or 24-hour customized
260.7 living services.

260.8 (b) The commissioner may approve an exception to the moratorium only when the
260.9 commissioner determines the exception is necessary for:

260.10 (1) a change of ownership at the same address;

260.11 (2) continuity of care due to a provider closure, decertification, licensing action, or other
260.12 service disruption; or

260.13 (3) compliance with federal law.

260.14 (c) In determining whether to approve an exception to the moratorium, the commissioner
260.15 must consider the availability of services in the geographic area, a person's assessed needs
260.16 and informed choice, whether a less restrictive alternative is available, and the
260.17 recommendation of the lead agency.

260.18 (d) A determination under this subdivision is final and not subject to appeal.

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

260.20 Sec. 25. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision
260.21 to read:

260.22 Subd. 4. Documentation of staffing; auditing and rate review for residential support
260.23 services. (a) For purposes of this subdivision, residential support services include 24-hour
260.24 customized living services, customized living services, family adult foster care, and corporate
260.25 adult foster care.

260.26 (b) Effective January 1, 2029, a provider enrolled to provide residential support services
260.27 under this subdivision must maintain documentation of direct staffing hours provided to
260.28 each person receiving services, including but not limited to documentation identifying:

260.29 (1) the name, role, and unique identifier for each staff person who provided services to
260.30 match records to payroll, time and attendance systems, and any other source documentation;

260.31 (2) the date services were provided;

261.1 (3) the total number of hours of direct support provided;

261.2 (4) awake overnight staffing hours provided, if applicable;

261.3 (5) asleep overnight staffing hours provided, if applicable; and

261.4 (6) any other staffing information required by the commissioner.

261.5 (c) A provider must maintain documentation in a manner and format determined by the
261.6 commissioner for at least six years. If a provider changes payroll vendors, merges operations,
261.7 or changes staffing identifiers, the provider must maintain a documented link between prior
261.8 and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and
261.9 role classification for each staff person.

261.10 (d) A provider must submit the documentation required under paragraph (b) to the
261.11 commissioner annually, in a manner and format determined by the commissioner. The
261.12 commissioner must establish multiple submission windows throughout the calendar year
261.13 and may assign providers to a submission window for administrative efficiency and system
261.14 capacity. Documentation must reflect staffing provided during the prior calendar year and
261.15 must be submitted no later than the final business day of the provider's assigned submission
261.16 window. The commissioner may conduct random or targeted validations and audits of
261.17 submitted data and may require supplemental documentation as necessary to verify accuracy
261.18 and compliance.

261.19 (e) The commissioner must conduct periodic analysis of documentation submitted under
261.20 this subdivision and may validate staffing data through random audits or other verification
261.21 methods.

261.22 (f) Based on the analysis under paragraph (e), the commissioner may provide
261.23 recommendations to lead agencies regarding modifications to the rate of the person receiving
261.24 services, including increases or decreases necessary to align the rate with staffing provided
261.25 to the person as demonstrated by the submitted historical staffing documentation.
261.26 Recommendations must be based on the requirements of this section and applicable federal
261.27 and state requirements governing rate setting.

261.28 (g) If a provider fails to submit documentation requested within the submission window
261.29 under paragraph (d), the commissioner must issue a written notice of noncompliance. If
261.30 documentation is not received within 60 days following the notice of noncompliance, the
261.31 commissioner may temporarily suspend payments to the provider until the required
261.32 documentation is submitted. The commissioner must make withheld payments to the provider
261.33 once the required documentation is received. If the noncompliance persists, the commissioner

262.1 may adjust future rate payments, require the provider to submit a corrective action plan, or
262.2 pursue other enforcement actions as authorized by law.

262.3 (h) The commissioner must publish annual aggregate reports summarizing audit findings
262.4 and trends related to staffing provided under this section.

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

262.6 **Sec. 26. MARKET RATE STUDY FOR HOME AND COMMUNITY-BASED**
262.7 **SERVICES.**

262.8 (a) The commissioner of human services must conduct a market rate study to evaluate
262.9 the adequacy, sustainability, and equity of payment rates for specific home and
262.10 community-based services under the home and community-based services waivers authorized
262.11 under Minnesota Statutes, sections 256B.092 and 256B.49.

262.12 (b) The study must include, at a minimum, an analysis of the following:

262.13 (1) employment support services delivered in remote or virtual settings;

262.14 (2) 24-hour emergency assistance;

262.15 (3) assistive technology;

262.16 (4) environmental accessibility adaptations;

262.17 (5) chore services;

262.18 (6) transitional services;

262.19 (7) independent living skills training;

262.20 (8) specialist services, including positive support services and orientation and mobility
262.21 services; and

262.22 (9) administrative fees charged by enrolled providers or vendors for services or purchased
262.23 goods.

262.24 (c) In planning and conducting the market rate study, the commissioner must consult
262.25 with interested parties, including but not limited to service providers, people with disabilities,
262.26 lead agencies, Tribal Nations, culturally specific and community-based providers, and
262.27 disability advocacy organizations. The consultation process must be designed to ensure
262.28 meaningful participation from providers in greater Minnesota and from providers serving
262.29 communities of color and Tribal Nations.

263.1 (d) In conducting the study, the commissioner must analyze provider costs, workforce
263.2 availability, wage competitiveness, regional market conditions, inflationary impacts, and
263.3 access issues. The commissioner must also evaluate whether current reimbursement
263.4 methodologies reflect actual costs of providing services and support long-term access to
263.5 qualified providers.

263.6 (e) By February 15, 2027, the commissioner must submit a report with findings and
263.7 recommendations, including but not limited to any proposed statutory changes, to the chairs
263.8 and ranking minority members of the legislative committees with jurisdiction over health
263.9 and human services policy and finance.

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

263.11 **Sec. 27. WAIVER CASE MANAGEMENT ADVISORY WORKING GROUP.**

263.12 Subdivision 1. **Establishment; purpose.** The commissioner of human services shall
263.13 convene a waiver case management advisory working group. The purpose of the working
263.14 group is to evaluate and make recommendations regarding the quality, workforce
263.15 sustainability, accountability, and long-term stability of home and community-based waiver
263.16 case management services provided under Minnesota Statutes, sections 256B.0913, 256B.092,
263.17 256B.0922, and 256B.49, and chapter 256S.

263.18 Subd. 2. **Membership.** The commissioner shall appoint members representing diverse
263.19 geographic regions of the state, including metropolitan and greater Minnesota areas, with
263.20 at least 30 percent of the members living or working outside the seven-county metropolitan
263.21 area and including:

263.22 (1) representatives of the Department of Human Services;

263.23 (2) lead agencies, as defined in Minnesota Statutes, section 256B.0911, subdivision 10;

263.24 (3) contracted waiver case management providers;

263.25 (4) waiver case managers with current direct service responsibilities;

263.26 (5) individuals receiving waiver services or their family members or advocates;

263.27 (6) representatives of disability advocacy organizations;

263.28 (7) representatives of the Minnesota Disability Law Center;

263.29 (8) representatives of culturally specific or Tribal communities; and

263.30 (9) workforce representatives with experience in human services.

264.1 Subd. 3. **Compensation; expenses.** Members of the working group may receive
264.2 compensation and expense reimbursement as provided in Minnesota Statutes, section 15.059,
264.3 subdivision 3.

264.4 Subd. 4. **Meetings; administrative support.** (a) The first meeting of the working group
264.5 must be convened no later than August 1, 2026. The working group must meet at least
264.6 monthly. Meetings are subject to Minnesota Statutes, chapter 13D. The working group may
264.7 meet by telephone or interactive technology consistent with Minnesota Statutes, section
264.8 13D.015.

264.9 (b) The Department of Human Services shall provide staff and administrative support
264.10 to convene the working group, facilitate working group meetings, and prepare the final
264.11 report.

264.12 Subd. 5. **Duties.** The working group shall:

264.13 (1) evaluate the impact of current funding levels, workforce capacity, administrative
264.14 requirements, and caseload expectations on service delivery and quality outcomes;

264.15 (2) examine accountability and oversight mechanisms and grievance processes across
264.16 delivery models;

264.17 (3) review available data related to workforce vacancies, turnover, compensation, and
264.18 service access;

264.19 (4) identify barriers to maintaining high-quality and culturally responsive case
264.20 management services;

264.21 (5) examine case management training requirements and core competencies;

264.22 (6) evaluate client transfer and service continuity processes; and

264.23 (7) develop recommendations, including potential legislative or administrative changes,
264.24 to ensure a stable, accountable, and high-quality waiver case management system that
264.25 supports person-centered planning and informed choice.

264.26 Subd. 6. **Report.** By September 1, 2027, the commissioner shall submit a report
264.27 summarizing the working group's findings and recommendations to the chairs and ranking
264.28 minority members of the legislative committees with jurisdiction over human services policy
264.29 and finance.

264.30 Subd. 7. **Expiration.** The working group expires upon submission of the report required
264.31 under subdivision 6.

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

265.1 **Sec. 28. DIRECTION TO COMMISSIONER; HCBS WAIVER CASE**

265.2 **MANAGEMENT EVALUATION AND REPORT.**

265.3 (a) The commissioner of human services must evaluate reimbursement rates and lead
265.4 agency duties associated with home and community-based services (HCBS) case management
265.5 under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S. The
265.6 commissioner must develop an updated payment methodology for waiver case management
265.7 that reasonably covers the cost to provide high-quality, person-centered, and culturally
265.8 responsive case management services. The report must, at a minimum, include:

265.9 (1) an evaluation of costs and workforce pressures that impact the delivery of case
265.10 management services;

265.11 (2) an evaluation of costs to provide culturally responsive case management services;

265.12 (3) an evaluation of current reimbursement rates, methodologies, and the extent to which
265.13 rates cover costs to provide services and attract and retain case managers;

265.14 (4) an evaluation of current caseload sizes and recommended best practices for caseload
265.15 and case mix;

265.16 (5) identification and evaluation of the required professional qualifications, experience,
265.17 and training of case management professionals; and

265.18 (6) recommended HCBS waiver rate methodology, specified cost components, weighted
265.19 values, and modeled rate frameworks.

265.20 (b) The commissioner must consult with interested parties, including but not limited to
265.21 lead agencies, contracted case management services providers, individuals receiving services
265.22 and their families, advocacy organizations, and relevant experts. The commissioner must
265.23 consider the recommendations of the waiver case management advisory working group
265.24 under section 27 when developing recommendations under this section.

265.25 (c) The commissioner may contract with rate experts to develop and model recommended
265.26 rates.

265.27 (d) By December 15, 2028, the commissioner of human services must submit a report
265.28 to the chairs and ranking minority members of the legislative committees with jurisdiction
265.29 over health and human services with the findings and recommendations of the evaluation.

265.30 **EFFECTIVE DATE.** This section is effective July 1, 2027.

266.1 **Sec. 29. INTEGRATED COMMUNITY SUPPORTS REFORM STUDY.**

266.2 **Subdivision 1. Review and evaluation.** The commissioner of human services must
266.3 review the medical assistance integrated community supports (ICS) service provided under
266.4 the home and community-based waivers authorized under Minnesota Statutes, sections
266.5 256B.092 and 256B.49, and evaluate the need for statutory, regulatory, and programmatic
266.6 reforms. At a minimum, the evaluation must include:

266.7 (1) an examination of current provider standards, service delivery models, and oversight
266.8 mechanisms applicable to ICS providers;

266.9 (2) an assessment of the effectiveness of ICS in supporting individuals to live
266.10 independently in community settings, including outcomes related to service utilization and
266.11 health and safety;

266.12 (3) a review of payment methodologies, including rate structures, administrative
266.13 components, and alignment with federal Medicaid requirements under home and
266.14 community-based services waivers and state plan authorities;

266.15 (4) an environmental scan of comparable supportive housing and community-based
266.16 service models in other states, including best practices for program integrity, quality
266.17 assurance, and service coordination;

266.18 (5) an assessment of program integrity risks, including billing practices and service
266.19 verification; and

266.20 (6) identification of opportunities to improve coordination between ICS providers and
266.21 lead agencies.

266.22 **Subd. 2. Stakeholder consultation.** The commissioner must consult with stakeholders
266.23 in conducting the review under this section. Stakeholders must include, at a minimum:

266.24 (1) individuals who receive ICS services and self-advocates;

266.25 (2) family members and caregivers of individuals who receive ICS services;

266.26 (3) ICS providers;

266.27 (4) counties and Tribal Nations serving as lead agencies; and

266.28 (5) advocacy organizations representing people with disabilities.

266.29 **Subd. 3. Report.** (a) The commissioner must develop recommendations for legislative
266.30 and administrative changes to strengthen the ICS program. Recommendations may include
266.31 but are not limited to:

- 267.1 (1) establishing risk-based provider oversight and program integrity requirements;
267.2 (2) clarifying allowable services and service limits consistent with federal Medicaid
267.3 requirements, including prohibitions on payment for room and board;
267.4 (3) improving service verification, documentation, and accountability measures;
267.5 (4) enhancing recipient protections, including person-centered planning and grievance
267.6 processes; and
267.7 (5) aligning ICS with home and community-based services settings requirements under
267.8 Code of Federal Regulations, title 42, section 441.301.

- 267.9 (b) The commissioner must submit a report to the chairs and ranking minority members
267.10 of the legislative committees with jurisdiction over health and human services policy and
267.11 finance by September 1, 2027. The report must include findings, stakeholder feedback, and
267.12 specific legislative proposals related to ICS reform.

267.13 **Sec. 30. MNCHOICES REDESIGN WORKING GROUP.**

- 267.14 Subdivision 1. **Establishment.** The commissioner of human services shall convene a
267.15 MnCHOICES redesign working group to develop recommendations related to state provision
267.16 of MnCHOICES assessments under Minnesota Statutes, section 256B.0911, subdivision
267.17 14, paragraph (g).

- 267.18 Subd. 2. **Membership.** At a minimum, the working group must include the following
267.19 members:

- 267.20 (1) two individuals receiving waiver services or the individuals' family members or
267.21 advocates, appointed by the commissioner in consultation with organizations representing
267.22 individuals with lived experience of disability and waiver services;

- 267.23 (2) three county representatives, appointed by the Minnesota Association of County
267.24 Social Service Administrators, including;

- 267.25 (i) at least one representative of a lead agency located in a metropolitan county, as defined
267.26 in Minnesota Statutes, section 473.121, subdivision 4; and

- 267.27 (ii) at least two representatives of lead agencies located outside of a metropolitan county,
267.28 as defined in Minnesota Statutes, section 473.121, subdivision 4;

- 267.29 (3) one staff member from the Minnesota Social Service Association, appointed by the
267.30 Minnesota Social Service Association;

- 267.31 (4) at least three representatives from Tribal Nations, appointed by the commissioner;

268.1 (5) two representatives of disability advocacy organizations, appointed by the
268.2 commissioner;

268.3 (6) one representative of aging services organizations, appointed by LeadingAge
268.4 Minnesota;

268.5 (7) one representative of aging services organizations, appointed by Care Providers of
268.6 Minnesota; and

268.7 (8) additional nonvoting participants as determined by the commissioner, which may
268.8 include staff from the Department of Human Services and other interested parties.

268.9 Subd. 3. **Duties.** The working group shall make recommendations to shift the
268.10 responsibility and administration of conducting MnCHOICES assessments to the state.

268.11 Recommendations must include:

268.12 (1) defined roles and responsibilities between county, Tribal Nation, and state functions;

268.13 (2) revised payment methodologies and financing of duties;

268.14 (3) efficient workflows between local and state functions;

268.15 (4) service continuity for people seeking and receiving long-term services and supports;

268.16 and

268.17 (5) methods for gathering public feedback and providing public awareness.

268.18 Subd. 4. **Terms, compensation, and removal.** The terms, compensation, and removal
268.19 of the working group members are governed by Minnesota Statutes, section 15.059.

268.20 Subd. 5. **Meetings; administrative support.** (a) The first meeting of the working group
268.21 must be convened no later than August 1, 2026. The working group must meet at least
268.22 monthly. The working group may meet by telephone or interactive technology consistent
268.23 with Minnesota Statutes, section 13D.015.

268.24 (b) The Department of Human Services shall provide staff and administrative support
268.25 to convene the working group, facilitate working group meetings, and prepare the final
268.26 report.

268.27 Subd. 6. **Report.** By September 1, 2027, the commissioner must submit a report of the
268.28 working group's findings and recommendations, including but not limited to any legislative
268.29 changes necessary to implement the recommendations, to the chairs and ranking minority
268.30 members of the legislative committees with jurisdiction over human services policy and
268.31 finance.

269.1 Subd. 7. **Expiration.** The working group expires upon submission of the report required
269.2 under subdivision 6.

269.3 Sec. 31. **REPEALER.**

269.4 Subdivision 1. **Electronic visit verification provider requirements.** Minnesota Statutes
269.5 2024, section 256B.073, subdivision 4, is repealed.

269.6 Subd. 2. **MnCHOICES exceptions following an institutional stay.** Minnesota Statutes
269.7 2024, section 256B.0911, subdivision 21, is repealed.

269.8 **EFFECTIVE DATE.** Subdivision 1 is effective July 1, 2026. Subdivision 2 is effective
269.9 January 1, 2027.

269.10

ARTICLE 8

269.11

MISCELLANEOUS

269.12 Section 1. Minnesota Statutes 2025 Supplement, section 15.471, subdivision 6, is amended
269.13 to read:

269.14 Subd. 6. **Party.** (a) Except as modified by paragraph (b), "party" means a person named
269.15 or admitted as a party, or seeking and entitled to be admitted as a party, in a court action or
269.16 contested case proceeding, or a person admitted by an administrative law judge for limited
269.17 purposes, and who is:

269.18 (1) an unincorporated business, partnership, corporation, association, or organization,
269.19 having not more than 500 employees at the time the civil action was filed or the contested
269.20 case proceeding was initiated; and

269.21 (2) an unincorporated business, partnership, corporation, association, or organization
269.22 whose annual revenues did not exceed ~~\$7,000,000~~ \$13,500,000 at the time the civil action
269.23 was filed or the contested case proceeding was initiated.

269.24 (b) "Party" also includes a partner, officer, shareholder, member, or owner of an entity
269.25 described in paragraph (a), clauses (1) and (2).

269.26 (c) "Party" does not include a person providing services pursuant to licensure or
269.27 reimbursement on a cost basis by ~~the Department of Health,~~ the Department of Human
269.28 Services; or Direct Care and Treatment when that person is named or admitted or seeking
269.29 to be admitted as a party in a matter which involves the licensing or reimbursement rates,
269.30 procedures, or methodology applicable to those services.

270.1 Sec. 2. Minnesota Statutes 2024, section 144G.41, subdivision 1, is amended to read:

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

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

270.4 (2) provide services in a manner that complies with the Nurse Practice Act in sections
270.5 148.171 to 148.285;

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

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

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

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

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

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

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

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

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

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

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

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

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

271.7 (i) awake;

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

271.10 (iii) capable of communicating with residents;

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

271.12 (v) capable of following directions; and

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

271.15 Sec. 3. Minnesota Statutes 2024, section 144G.41, is amended by adding a subdivision to
271.16 read:

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

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

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

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

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

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

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

272.3 (3) a staff model health plan company;

272.4 (4) an ambulance service required to be licensed;

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

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

272.11 (b) Health care provider does not include:

272.12 (1) hospitals; medical supplies distributors, except as specified under paragraph (a),
272.13 clause (5); nursing homes licensed under chapter 144A or licensed in any other jurisdiction;
272.14 wholesale drug distributors; pharmacies; surgical centers; bus and taxicab transportation,
272.15 or any other providers of transportation services other than ambulance services required to
272.16 be licensed; supervised living facilities for persons with developmental disabilities, licensed
272.17 under Minnesota Rules, parts 4665.0100 to 4665.9900; ~~housing with services establishments~~
272.18 ~~required to be registered under chapter 144D~~ assisted living facilities licensed under chapter
272.19 144G; board and lodging establishments providing only custodial services that are licensed
272.20 under chapter 157 and registered under section 157.17 to provide supportive services or
272.21 health supervision services; adult foster homes as defined in Minnesota Rules, part
272.22 9555.5105; day training and habilitation services for adults with developmental disabilities
272.23 as defined in section 252.41, subdivision 3; boarding care homes, as defined in Minnesota
272.24 Rules, part 4655.0100; and adult day care centers as defined in Minnesota Rules, part
272.25 9555.9600;

272.26 (2) home health agencies as defined in Minnesota Rules, part 9505.0175, subpart 15; a
272.27 person providing personal care assistance services and supervision of personal care assistance
272.28 services as defined in ~~Minnesota Rules, part 9505.0335~~ section 256B.0625, subdivision
272.29 19a; a person providing home care nursing services as defined in Minnesota Rules, part
272.30 9505.0360; and home care providers required to be licensed under chapter 144A for home
272.31 care services provided under chapter 144A;

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

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

273.4 (5) a person who receives all payments for patient services from health care providers,
273.5 surgical centers, or hospitals for goods and services that are taxable to the paying health
273.6 care providers, surgical centers, or hospitals, as provided under section 295.53, subdivision
273.7 1, paragraph (b), clause (3) or (4), or from a source of funds that is excluded or exempt from
273.8 tax under sections 295.50 to 295.59.

273.9 Sec. 5. Minnesota Statutes 2025 Supplement, section 295.50, subdivision 9b, is amended
273.10 to read:

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

273.14 (1) bed and board;

273.15 (2) nursing services and other related services;

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

273.17 (4) medical social services;

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

273.19 (6) other diagnostic or therapeutic items or services;

273.20 (7) medical or surgical services;

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

273.22 and

273.23 (9) emergency services.

273.24 (b) "Patient services" does not include:

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

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

273.28 (3) services provided to and by community residential mental health facilities licensed
273.29 under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by

274.1 residential treatment programs for children with a serious mental illness licensed or certified
274.2 under chapter 245A;

274.3 (4) services provided under the following programs: day treatment services as defined
274.4 in section 245.462, subdivision 8; assertive community treatment as described in section
274.5 256B.0622; adult rehabilitative mental health services as described in section 256B.0623;
274.6 crisis response services as described in section 256B.0624; and children's therapeutic services
274.7 and supports as described in section 256B.0943;

274.8 (5) services provided to and by community mental health centers as defined in section
274.9 245.62, subdivision 2;

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

274.12 (7) hospice care services;

274.13 (8) home and community-based waived services under chapter 256S and sections
274.14 256B.49 and 256B.501;

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

274.17 (10) services provided to the following: supervised living facilities for persons with
274.18 developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;
274.19 ~~housing with services establishments required to be registered under chapter 144D~~ assisted
274.20 living facilities licensed under chapter 144G; board and lodging establishments providing
274.21 only custodial services that are licensed under chapter 157 and registered under section
274.22 157.17 to provide supportive services or health supervision services; adult foster homes as
274.23 defined in Minnesota Rules, part 9555.5105; day training and habilitation services for adults
274.24 with developmental disabilities as defined in section 252.41, subdivision 3; boarding care
274.25 homes as defined in Minnesota Rules, part 4655.0100; adult day care services as defined
274.26 in section 245A.02, subdivision 2a; and home health agencies as defined in Minnesota
274.27 Rules, part 9505.0175, subpart 15, or licensed under chapter 144A.

274.28 **Sec. 6. DIRECTION TO COMMISSIONER; ASSESSMENT OF ADMINISTRATION**
274.29 **ROLES.**

274.30 (a) The commissioner of human services, in consultation with Tribal Nations and counties,
274.31 must conduct a study to assess and recommend improvements to the roles and responsibilities
274.32 of the state agency, counties, and Tribal Nations in administering human services programs.

275.1 (b) The study must include a comprehensive review of programs administered by the
275.2 department, including but not limited to medical assistance, MinnesotaCare, behavioral
275.3 health services, long-term services and supports, housing and homelessness programs,
275.4 Minnesota supplemental aid, general assistance, and licensing and oversight functions.

275.5 (c) The study must evaluate the:

275.6 (1) current roles and responsibilities held by the state agency, counties, and Tribal Nations
275.7 in administering human services programs, including but not limited to the challenges and
275.8 benefits of the current delegation of roles and responsibilities;

275.9 (2) lived experience of people accessing human services programs related to the
275.10 delegation of administrative duties;

275.11 (3) financing of human services program administration across the state agency, counties,
275.12 and Tribal Nations;

275.13 (4) variations in service delivery between different geographical regions of the state;
275.14 and

275.15 (5) administration of human services programs in other states, focusing on the roles and
275.16 responsibilities of the local governments versus the state Medicaid or human services agency,
275.17 and identifying the benefits, challenges, and financing of the delegation of duties.

275.18 (d) The study must focus on the goals of transforming the human services system to
275.19 ensure a transparent, accessible, accountable, equitable, and effective human services system.

275.20 (e) The study must provide recommendations for the optimal delegation of duties between
275.21 the state agency, counties, and Tribal Nations in the delivery of human services.

275.22 Recommendations must include:

275.23 (1) how the delegation of duties will improve the experience of people accessing human
275.24 services;

275.25 (2) implementation and timing considerations to ensure continuity of services;

275.26 (3) systems technology adaptations required;

275.27 (4) workforce considerations; and

275.28 (5) financing strategies and the estimated fiscal impact to the state budget.

275.29 (f) By October 1, 2028, the commissioner must submit a report on the study and
275.30 recommendations to the chairs and ranking minority members of the legislative committees
275.31 with jurisdiction over health and human services policy and finance.

ARTICLE 9

DEPARTMENT OF HUMAN SERVICES APPROPRIATIONS

Section 1. HUMAN SERVICES APPROPRIATIONS.

The dollar amounts 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 9, article 12, from the general fund or any fund named for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal years ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

		<u>APPROPRIATIONS</u>	
		<u>Available for the Year</u>	
		<u>Ending June 30</u>	
		<u>2026</u>	<u>2027</u>
276.16	Sec. 2. <u>TOTAL APPROPRIATION</u>	\$	<u>-0-</u> \$ <u>35,862,000</u>

	<u>Appropriations by Fund</u>		
		<u>2026</u>	<u>2027</u>
276.19	<u>General</u>	<u>-0-</u>	<u>33,849,000</u>
276.20	<u>Special Government</u>		
276.21	<u>Revenue Fund</u>	<u>-0-</u>	<u>2,013,000</u>

276.22	Sec. 3. <u>CENTRAL OFFICE; OPERATIONS</u>	\$	<u>-0-</u> \$ <u>27,395,000</u>
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Subdivision 1. Evaluation of DHS Structure and Processes

\$500,000 in fiscal year 2027 is for a comprehensive evaluation of the Department of Human Services structure and processes.

This is a onetime appropriation and is available until June 30, 2028.

Subd. 2. Assessment of State, County, and Tribal Nation Roles in Administering Human Services Programs

\$3,000,000 in fiscal year 2027 is for an assessment of state, county, and Tribal Nation roles in administering human services

277.1 programs. This is a onetime appropriation and
 277.2 is available until June 30, 2029.

277.3 **Subd. 3. Base Level Adjustment**

277.4 The general fund base is increased by
 277.5 \$18,756,000 in fiscal year 2028 and increased
 277.6 by \$16,639,000 in fiscal year 2029.

277.7 **Sec. 4. CENTRAL OFFICE; HEALTH CARE** \$ -0- \$ 24,795,000

277.8 **Base Level Adjustment** The general fund
 277.9 base is increased by \$45,195,000 in fiscal year
 277.10 2028 and increased by \$45,160,000 in fiscal
 277.11 year 2029.

277.12 **Sec. 5. CENTRAL OFFICE; AGING AND**
 277.13 **DISABILITY SERVICES** \$ -0- \$ 17,745,000

277.14 **Subdivision 1. Market Rate and Homemaker**
 277.15 **Services Rate Study**

277.16 \$500,000 in fiscal year 2027 is for a study on
 277.17 rate setting methodologies for services
 277.18 currently offered under market rate
 277.19 methodologies and homemaker services. This
 277.20 is onetime appropriation and is available until
 277.21 June 30, 2028.

277.22 **Subd. 2. Waiver Case Management Study**

277.23 \$300,000 in fiscal year 2027 is for a study on
 277.24 waiver case management services. This is a
 277.25 onetime appropriation and is available until
 277.26 June 30, 2028.

277.27 **Subd. 3. Base Level Adjustment**

277.28 The general fund base is increased by
 277.29 \$28,665,000 in fiscal year 2028 and increased
 277.30 by \$29,405,000 in fiscal year 2029.

277.31 **Sec. 6. CENTRAL OFFICE; BEHAVIORAL**
 277.32 **HEALTH** \$ -0- \$ 1,634,000

278.1 Subdivision 1. Access to Services for
 278.2 Incarcerated Individuals Evaluation

278.3 \$150,000 in fiscal year 2027 is for community
 278.4 engagement and evaluation related reentry
 278.5 services.

278.6 Subd. 2. Base Level Adjustment

278.7 The general fund base is increased by
 278.8 \$2,094,000 in fiscal year 2028 and increased
 278.9 by \$2,077,000 in fiscal year 2029.

278.10 Sec. 7. CENTRAL OFFICE; OFFICE OF
 278.11 INSPECTOR GENERAL \$ -0- \$ 39,721,000

278.12 Subdivision 1. Appropriations by Fund

278.13	<u>Appropriations by Fund</u>	
278.14	<u>2026</u>	<u>2027</u>
278.15 <u>General Fund</u>	<u>-0-</u>	<u>37,708,000</u>
278.16 <u>Special Government</u>		
278.17 <u>Revenue Fund</u>	<u>-0-</u>	<u>2,013,000</u>

278.18 Subd. 2. Base Level Adjustment

278.19 The general fund base is increased by
 278.20 \$38,457,000 in fiscal year 2028 and increased
 278.21 by \$38,457,000 in fiscal year 2029. The
 278.22 special revenue government fund base is
 278.23 increased by \$2,352,000 in fiscal year 2028
 278.24 and increased by \$2,352,000 in fiscal year
 278.25 2029.

278.26 Sec. 8. FORECASTED PROGRAMS;
 278.27 HOUSING SUPPORT \$ -0- \$ 10,057,000

278.28 Sec. 9. FORECASTED PROGRAMS;
 278.29 MEDICAL ASSISTANCE \$ -0- \$ (64,971,000)

278.30 Sec. 10. FORECASTED PROGRAMS;
 278.31 ALTERNATIVE CARE \$ -0- \$ (141,000)

278.32 Sec. 11. FORECASTED PROGRAMS;
 278.33 BEHAVIORAL HEALTH FUND \$ -0- \$ (19,248,000)

278.34 Sec. 12. GRANT PROGRAMS; HOUSING
 278.35 GRANTS \$ -0- \$ 192,000

280.1 16A.28, subdivision 3, this appropriation is
 280.2 available until June 30, ~~2027~~ 2028.

280.3 **(d) Reimbursement for Community-First**
 280.4 **Services and Supports Workers Report.**

280.5 \$250,000 in fiscal year 2025 is for a contract
 280.6 related to the reimbursement for
 280.7 community-first services and supports workers
 280.8 report. This is a onetime appropriation.

280.9 Notwithstanding Minnesota Statutes, section
 280.10 16A.28, subdivision 3, this appropriation is
 280.11 available until June 30, 2026.

280.12 **(e) Carryforward Authority.**

280.13 Notwithstanding Minnesota Statutes, section
 280.14 16A.28, subdivision 3, \$758,000 in fiscal year
 280.15 2025 is available until June 30, 2026, and
 280.16 \$2,687,000 in fiscal year 2025 is available
 280.17 until June 30, 2027.

280.18 **(f) Base Level Adjustment.** The general fund
 280.19 base is increased by \$340,000 in fiscal year
 280.20 2026 and increased by \$340,000 in fiscal year
 280.21 2027.

280.22 Sec. 17. Laws 2024, chapter 125, article 8, section 2, subdivision 14, as amended by Laws
 280.23 2025, First Special Session chapter 9, article 12, section 29, is amended to read:

280.24 Subd. 14. Grant Programs; Disabilities Grants	1,650,000	9,574,000
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280.25 **(a) Capital Improvement for Accessibility.**

280.26 \$400,000 in fiscal year 2025 is for a payment
 280.27 to Anoka County to make capital
 280.28 improvements to existing space in the Anoka
 280.29 County Human Services building in the city
 280.30 of Blaine, including making bathrooms fully
 280.31 compliant with the Americans with Disabilities
 280.32 Act with adult changing tables and ensuring
 280.33 barrier-free access for the purposes of
 280.34 improving and expanding the services an

281.1 existing building tenant can provide to adults
281.2 with developmental disabilities. This is a
281.3 onetime appropriation.

281.4 **(b) Dakota County Disability Services**
281.5 **Workforce Shortage Pilot Project.** \$500,000
281.6 in fiscal year 2025 is for a grant to Dakota
281.7 County for innovative solutions to the
281.8 disability services workforce shortage. Up to
281.9 \$250,000 of this amount must be used to
281.10 develop and test an online application for
281.11 matching requests for services from people
281.12 with disabilities to available staff, and up to
281.13 \$250,000 of this amount must be used to
281.14 develop a communities-for-all program that
281.15 engages businesses, community organizations,
281.16 neighbors, and informal support systems to
281.17 promote community inclusion of people with
281.18 disabilities. By October 1, 2026, the
281.19 commissioner shall report the outcomes and
281.20 recommendations of these pilot projects to the
281.21 chairs and ranking minority members of the
281.22 legislative committees with jurisdiction over
281.23 human services finance and policy. This is a
281.24 onetime appropriation. Notwithstanding
281.25 Minnesota Statutes, section 16A.28,
281.26 subdivision 3, this appropriation is available
281.27 until June 30, 2027.

281.28 **(c) Pediatric Hospital-to-Home Transition**
281.29 **Pilot Program.** \$1,040,000 in fiscal year 2025
281.30 is for the pediatric hospital-to-home pilot
281.31 program. This is a onetime appropriation.
281.32 Notwithstanding Minnesota Statutes, section
281.33 16A.28, subdivision 3, this appropriation is
281.34 available until June 30, ~~2027~~ 2028.

- 282.1 **(d) Artists With Disabilities Support.**
282.2 \$690,000 in fiscal year 2025 is for a payment
282.3 to a nonprofit organization licensed under
282.4 Minnesota Statutes, chapter 245D, located on
282.5 Minnehaha Avenue West in Saint Paul, and
282.6 that supports artists with disabilities in creating
282.7 visual and performing art that challenges
282.8 society's views of persons with disabilities.
282.9 This is a onetime appropriation.
282.10 Notwithstanding Minnesota Statutes, section
282.11 16A.28, subdivision 3, this appropriation is
282.12 available until June 30, 2027.
- 282.13 **(e) Emergency Relief Grants for Rural**
282.14 **EIDBI Providers.** \$600,000 in fiscal year
282.15 2025 is for emergency relief grants for EIDBI
282.16 providers. This is a onetime appropriation.
282.17 Notwithstanding Minnesota Statutes, section
282.18 16A.28, subdivision 3, this appropriation is
282.19 available until June 30, 2027.
- 282.20 **(f) Self-Advocacy Grants for Persons with**
282.21 **Intellectual and Developmental Disabilities.**
282.22 \$250,000 in fiscal year 2025 is for
282.23 self-advocacy grants under Minnesota Statutes,
282.24 section 256.477, subdivision 1, paragraph (a),
282.25 clauses (5) to (7), and for administrative costs.
282.26 This is a onetime appropriation and is
282.27 available until June 30, 2027.
- 282.28 **(g) Electronic Visit Verification**
282.29 **Implementation Grants.** \$864,000 in fiscal
282.30 year 2025 is for electronic visit verification
282.31 implementation grants. This is a onetime
282.32 appropriation. Notwithstanding Minnesota
282.33 Statutes, section 16A.28, subdivision 3, this
282.34 appropriation is available until June 30, 2027.

- 283.1 **(h) Aging and Disability Services for**
283.2 **Immigrant and Refugee Communities.**
283.3 \$250,000 in fiscal year 2025 is for a payment
283.4 to SEWA-AIFW to address aging, disability,
283.5 and mental health needs for immigrant and
283.6 refugee communities. This is a onetime
283.7 appropriation and is available until June 30,
283.8 2027.
- 283.9 **(i) License Transition Support for Small**
283.10 **Disability Waiver Providers.** \$3,150,000 in
283.11 fiscal year 2025 is for license transition
283.12 payments to small disability waiver providers.
283.13 This is a onetime appropriation.
283.14 Notwithstanding Minnesota Statutes, section
283.15 16A.28, subdivision 3, this appropriation is
283.16 available until June 30, 2027.
- 283.17 **(j) Own home services provider**
283.18 **capacity-building grants.** \$1,519,000 in fiscal
283.19 year 2025 is for the own home services
283.20 provider capacity-building grant program.
283.21 Notwithstanding Minnesota Statutes, section
283.22 16A.28, subdivision 3, this appropriation is
283.23 available until June 30, 2027. This is a onetime
283.24 appropriation.
- 283.25 **(k) Continuation of Centers for**
283.26 **Independent Living HCBS Access Grants.**
283.27 \$311,000 in fiscal year 2024 is for continued
283.28 funding of grants awarded under Laws 2021,
283.29 First Special Session chapter 7, article 17,
283.30 section 19, as amended by Laws 2022, chapter
283.31 98, article 15, section 15. This is a onetime
283.32 appropriation and is available until June 30,
283.33 2025.
- 283.34 **(l) Base Level Adjustment.** The general fund
283.35 base is increased by \$811,000 in fiscal year

284.1 2026 and increased by \$811,000 in fiscal year
 284.2 2027.

284.3 Sec. 18. APPROPRIATIONS GIVEN EFFECT ONCE.

284.4 If an appropriation or transfer in this article is enacted more than once during the 2026
 284.5 regular session, the appropriation or transfer must be given effect once.

284.6 Sec. 19. EXPIRATION OF UNCODIFIED LANGUAGE.

284.7 All uncodified language contained in this article expires on June 30, 2027, unless a
 284.8 different expiration date is explicit.

284.9 **ARTICLE 10**

284.10 **OTHER AGENCY APPROPRIATIONS**

284.11 Section 1. OTHER AGENCY APPROPRIATIONS.

284.12 The dollar amounts shown in the columns marked "Appropriations" are added to or, if
 284.13 shown in parentheses, are subtracted from the appropriations in Laws 2025, First Special
 284.14 Session chapter 9, article 14, from the general fund or any fund named for the purposes
 284.15 specified in this article, to be available for the fiscal year indicated for each purpose. The
 284.16 figures "2026" and "2027" used in this article mean that the appropriations listed under them
 284.17 are available for the fiscal years ending June 30, 2026, or June 30, 2027, respectively. "The
 284.18 first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is
 284.19 fiscal years 2026 and 2027.

		<u>APPROPRIATIONS</u>	
		<u>Available for the Year</u>	
		<u>Ending June 30</u>	
		<u>2026</u>	<u>2027</u>
284.24	Sec. 2. <u>COMMISSIONER OF HEALTH;</u>		
284.25	<u>TOTAL APPROPRIATION</u>	\$ -0-	\$ <u>1,125,000</u>
284.26	<u>The amounts that may be spent for each</u>		
284.27	<u>purpose are specified in the following sections.</u>		
284.28	Sec. 3. <u>HEALTH IMPROVEMENT</u>	\$ -0-	\$ <u>1,125,000</u>
284.29	Sec. 4. <u>DEPARTMENT OF CHILDREN,</u>		
284.30	<u>YOUTH, AND FAMILIES</u>		
284.31	<u>Subdivision 1. Operations and Administration:</u>		
284.32	<u>Agency-wide Supports</u>	\$ -0-	\$ <u>3,304,000</u>

285.1 **Subd. 2. Assessment of State, County, and Tribal**
285.2 **Nation Roles in Administering Human Services**
285.3 **Programs**

285.4 \$2,500,000 in fiscal year 2027 is for an
285.5 assessment of state, county, and Tribal Nation
285.6 roles in administering human services
285.7 programs. This is a onetime appropriation and
285.8 is available until June 30, 2029.

285.9 **Sec. 5. APPROPRIATIONS GIVEN EFFECT ONCE.**

285.10 If an appropriation or transfer in this article is enacted more than once during the 2026
285.11 regular session, the appropriation or transfer must be given effect once.

285.12 **Sec. 6. EXPIRATION OF UNCODIFIED LANGUAGE.**

285.13 All uncodified language contained in this article expires on June 30, 2027, unless a
285.14 different expiration date is explicit.

APPENDIX
Article locations for H4338-2

ARTICLE 1	HEALTH CARE.....	Page.Ln 2.26
	DEPARTMENT OF HUMAN SERVICES OFFICE OF INSPECTOR	
ARTICLE 2	GENERAL POLICY.....	Page.Ln 75.26
ARTICLE 3	BACKGROUND STUDIES.....	Page.Ln 126.8
ARTICLE 4	BEHAVIORAL HEALTH.....	Page.Ln 132.19
ARTICLE 5	UNIFORM SERVICE STANDARDS.....	Page.Ln 151.1
ARTICLE 6	UNIFORM SERVICE STANDARDS CONFORMING CHANGES....	Page.Ln 217.13
ARTICLE 7	AGING AND DISABILITY SERVICES.....	Page.Ln 230.6
ARTICLE 8	MISCELLANEOUS.....	Page.Ln 269.10
ARTICLE 9	DEPARTMENT OF HUMAN SERVICES APPROPRIATIONS.....	Page.Ln 276.1
ARTICLE 10	OTHER AGENCY APPROPRIATIONS.....	Page.Ln 284.9

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.

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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;

APPENDIX
Repealed Minnesota Statutes: H4338-2

- (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.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;
- (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.

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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.055 ELIGIBILITY CATEGORIES.

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the eligibility requirements in section 256B.056, is not eligible for medical assistance, except for covered services received while an inpatient in a medical institution as defined in Code of Federal Regulations, title 42, section 435.1010. Security issues, including costs, related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

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;

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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 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;

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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;
- (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.

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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.

(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.

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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;

(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

APPENDIX
Repealed Minnesota Statutes: H4338-2

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.

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.

APPENDIX
Repealed Minnesota Statutes: H4338-2

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.

(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;

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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;

(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.0701 RECUPERATIVE CARE SERVICES.

Subd. 11. **Requirements for provider enrollment; compliance training.** (a) Effective January 1, 2027, to enroll as a recuperative care provider, a provider must require all owners of the provider who are active in the day-to-day management and operations of the agency and all managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

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

(2) enrollment requirements;

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

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the provider and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the provider. If an individual moves to another recuperative care provider and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) Any recuperative care provider enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

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.

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subd. 21. **MnCHOICES assessments; exceptions following institutional stay.** (a) A person receiving home and community-based waiver services under section 256B.0913, 256B.092, or 256B.49 or chapter 256S may return to a community with home and community-based waiver services under the same waiver without being assessed or reassessed under this section if the person temporarily entered one of the following for 121 or fewer days:

- (1) a hospital;
- (2) an institution of mental disease;
- (3) a nursing facility;
- (4) an intensive residential treatment services program;
- (5) a transitional care unit; or
- (6) an inpatient substance use disorder treatment setting.

(b) Nothing in paragraph (a) changes annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

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.

(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

APPENDIX
Repealed Minnesota Statutes: H4338-2

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 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.

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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;

(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;

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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 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

APPENDIX
Repealed Minnesota Statutes: H4338-2

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. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.

APPENDIX
Repealed Minnesota Statutes: H4338-2

(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).

9505.2165 DEFINITIONS.

Subp. 4. **Fraud.** "Fraud" means:

A. acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes, including the following:

- (1) theft in violation of Minnesota Statutes, section 609.52;
- (2) perjury in violation of Minnesota Statutes, section 609.48;
- (3) aggravated forgery and forgery in violation of Minnesota Statutes, sections 609.625 and 609.63;
- (4) medical assistance fraud in violation of Minnesota Statutes, section 609.466; and
- (5) financial transaction card fraud in violation of Minnesota Statutes, section 609.821;

B. making a false statement, false claim, or false representation to a program where the person knows or should reasonably know the statement, claim, or representation is false, including knowingly and willfully submitting a false or fraudulent application for provider status; and

C. a felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section 952.