State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 4969

04/13/2026 Authored by Bierman
The bill was read for the first time and referred to the Committee on Rules and Legislative Administration

A bill for an act

relating to human services; modifying human services provisions on aging and health care, behavioral health, housing, licensing and program integrity, mental health licensing, background studies, and forecasted program appropriations adjustments; requiring reports; appropriating money; amending Minnesota Statutes 2024, sections 62D.04, subdivision 5; 142B.15; 142B.79; 144.057, subdivision 1; 144.292, subdivision 6; 245.4661, subdivision 10, by adding subdivisions; 245.4711, subdivision 5; 245.4881, subdivision 5; 245.735, subdivision 6; 245A.10, by adding a subdivision; 245A.65, subdivision 1a; 245C.03, subdivisions 1, 2, 3, 4, 5a, 5b, 7, 9, 10, 12, by adding subdivisions; 245C.04, subdivisions 1, 4a; 245C.10, subdivisions 4, 5, 8, 17; 245C.14, subdivisions 1, 2; 245C.24, subdivision 2; 245D.09, subdivisions 6, 7; 245G.03, subdivision 1; 245I.011, subdivisions 3, 5, by adding a subdivision; 245I.02, subdivisions 33, 39, by adding subdivisions; 245I.03, subdivision 4, by adding a subdivision; 245I.06, subdivisions 1, 2; 245I.07; 245I.10, subdivisions 6, 8, by adding a subdivision; 252.27, by adding subdivisions; 254A.03, subdivision 2; 254B.06, subdivision 2; 256.01, by adding a subdivision; 256B.04, subdivision 27, by adding a subdivision; 256B.05, subdivision 1; 256B.056, subdivisions 1, 2a, 3d, 7, 7a; 256B.0561, subdivision 2; 256B.06, subdivision 4; 256B.061; 256B.0623, subdivisions 1, 3, 12; 256B.0624, subdivisions 1, 4, by adding a subdivision; 256B.0625, subdivisions 3c, 3d, by adding subdivisions; 256B.0631, subdivision 1a, by adding subdivisions; 256B.0658; 256B.076, subdivision 1, by adding subdivisions; 256B.0761, subdivision 2; 256B.094, subdivisions 2, 3, 6, 7; 256B.0943, subdivisions 2, 5a; 256B.14, subdivision 2; 256B.198; 256B.69, subdivision 1; 256B.75; 256L.03, subdivision 1; 256L.04, subdivision 14; 295.52, subdivision 8; 297E.02, subdivision 3; Minnesota Statutes 2025 Supplement, sections 142A.09, subdivision 1; 142B.05, subdivision 3; 142B.10, subdivision 14; 245.4661, subdivision 9; 245A.03, subdivision 2; 245A.04, subdivision 7; 245A.05; 245A.07, subdivision 3; 245A.10, subdivisions 3, 4; 245C.02, subdivision 15a; 245C.03, subdivision 6; 245C.05, subdivisions 5, 5a; 245C.08, subdivision 1; 245C.10, subdivisions 6, 9, 22; 245C.13, subdivision 2; 245C.16, subdivision 1; 245C.22, subdivision 5; 245I.04, subdivisions 5, 17; 254B.02, subdivision 5; 254B.03, subdivision 4; 254B.0503, subdivision 1; 254B.0509, subdivision 2; 256.01, subdivision 2; 256.9657, subdivision 2b; 256.969, subdivision 2f; 256B.04, subdivision 21; 256B.0625, subdivisions 5m, 20; 256B.0911, subdivision 14; 256B.0924, subdivision 6; 256B.0943, subdivisions 3, 12; 256B.1973, subdivision 9; 256I.04, subdivision 2c; 260E.14, subdivision 1; 626.5572, subdivision 13; Laws 2025, First Special Session chapter 3, article 22, sections 2; 4, subdivision 1, by adding a subdivision;

Laws 2025, First Special Session chapter 9, article 4, sections 2; 23; 38; 39; 40; 41; 42; 43; 44; 50; 51; article 12, section 21; proposing coding for new law in Minnesota Statutes, chapters 245A; 245I; 256B; repealing Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, 8; 245C.03, subdivisions 3a, 3b, 5, 6a, 7, 9a; 245C.04, subdivisions 2, 3, 4, 5, 7, 8, 9, 10, 11; 245I.20, subdivision 9; 245I.23, subdivision 23; 256B.0371, subdivisions 1, 2, 4; 256B.051, subdivisions 1, 4, 7; 256B.055, subdivision 14; 256B.0623, subdivisions 2, 4, 5, 6, 9; 256B.0624, subdivisions 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9, 11; 256B.0943, subdivisions 4, 5, 5a, 6, 7, 11; Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3, 4d; 245C.04, subdivisions 6, 12, 13; 256B.0371, subdivision 3; 256B.051, subdivisions 2, 3, 5, 6, 6a, 6b, 8, 9, 10; 256B.0943, subdivisions 1, 9; 256B.695; 256B.696; Laws 2025, First Special Session chapter 3, article 18, section 3.

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

ARTICLE 1

HEALTH CARE

Section 1. Minnesota Statutes 2024, section 144.292, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

(5) $500 for any request.

(d) A provider or its representative may charge a $10 retrieval fee, but must not charge a per page fee or x-ray fee to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act or for purposes of a disability determination by the department's state medical review team. Notwithstanding the foregoing, a provider or its representative must not charge a fee, including a retrieval fee, to provide copies of records requested by a patient or the patient's authorized representative if the request for copies of records is for purposes of appealing a denial of Social Security disability income or Social Security disability benefits under title II or title XVI of the Social Security Act or for purposes of a disability determination by the department's state medical review team when the patient is receiving public assistance, represented by an attorney on behalf of a civil legal services program, or represented by a volunteer attorney program based on indigency. The patient or the patient's representative must submit one of the following to show that they are entitled to receive records without charge under this paragraph:

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

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

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

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

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

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

Sec. 2. Minnesota Statutes 2024, section 245.4711, subdivision 5, is amended to read:

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

(b) At a minimum, the case manager must have at least one case management contact with a documented core service component, as defined by the commissioner, to claim reimbursement for adult mental health targeted case management. Adult mental health case managers must not conduct the required case management contact by telephone with the

adult client or the adult client's legal representative for more than two consecutive calendar months.

Sec. 3. Minnesota Statutes 2024, section 245.4881, subdivision 5, is amended to read:

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

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

Sec. 4. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

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

Sec. 5. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 1b. **Definitions.** (a) For purposes of this section, the following terms have the meanings given.

(b) "Income" means the adjusted gross income of the natural or adoptive parents determined according to the previous year's federal tax form, except that taxable capital gains used to purchase a home are not counted as income.

(c) "Insurance" means health and accident insurance coverage enrollment in a nonprofit health service plan, health maintenance organization, self-insured plan, or preferred provider organization.

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

Sec. 6. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 7. **Parental responsibility.** Parents with household adjusted gross income equal to or greater than 675 percent of the federal poverty guidelines are responsible for a portion of the cost of services according to subdivision 8 if:

(1) insurance or other health care benefits pay some but not all of the cost of services; and

(2) no insurance or other health care benefits are available.

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

Sec. 7. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 8. **Contribution amount.** (a) The natural or adoptive parents of a minor child, not including a child determined eligible for medical assistance without consideration of parental income under the Tax Equity and Fiscal Responsibility Act option or a child accessing home and community-based waiver services, must contribute to the cost of services used by making monthly payments on a sliding scale based on income unless:

(1) the child is married or has been married;

(2) parental rights have been terminated; or

(3) the child's adoption is subsidized according to chapter 259A or through title IV-E of the Social Security Act.

(b) The parental contribution is a partial or full payment for medical services provided for diagnostic, therapeutic, curing, treating, mitigating, rehabilitation, maintenance, and personal care services as defined in United States Code, title 26, section 213, needed by the child with a chronic illness or disability.

(c) For households with adjusted gross income equal to or greater than 675 percent of federal poverty guidelines, the commissioner must compute the parental contribution by applying the following schedule of rates to the adjusted gross income of the natural or adoptive parents:

(1) if the adjusted gross income is equal to or greater than 675 percent of federal poverty guidelines and less than 975 percent of federal poverty guidelines, the commissioner must determine the parental contribution using a sliding fee scale established by the commissioner that begins at 4.5 percent of adjusted gross income at 675 percent of federal poverty

guidelines and increases to 5.99 percent of adjusted gross income for those with adjusted gross income up to 975 percent of federal poverty guidelines; and

(2) if the adjusted gross income is equal to or greater than 975 percent of federal poverty guidelines, the parental contribution must be 7.49 percent of adjusted gross income.

(d) If the child lives with the parent, the commissioner must reduce the annual adjusted gross income by $2,400 before calculating the parental contribution. If the child resides in an institution specified in section 256B.35, the parent is responsible for the personal needs allowance specified under section 256B.35 in addition to the parental contribution determined under this section. The parental contribution is reduced by any amount required to be paid directly to the child pursuant to a court order, but only if actually paid.

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

Sec. 8. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 9. **Household size; contribution adjustments.** (a) The household size used in determining the amount of contribution under subdivision 8 includes natural and adoptive parents and their dependents, including the child receiving services.

(b) The commissioner must implement adjustments in the contribution amount due to annual changes in the federal poverty guidelines on the first day of July following publication of the changes.

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

Sec. 9. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 10. **Contribution explained in writing.** (a) The commissioner must explain the contribution in writing to the parents at the time eligibility for services is determined. The parents must make the contribution on a monthly basis starting with the first month in which the child receives services.

(b) Annually upon redetermination or at termination of eligibility, if the contribution exceeded the cost of services provided, the local agency or the state must reimburse the excess amount to the parents either by direct reimbursement if the parent is no longer required to pay a contribution or by a reduction in or waiver of parental fees until the excess amount is exhausted. All reimbursements must include a notice that the amount reimbursed may be taxable income if the parent paid for the parent's fees through an employer's health care

flexible spending account under the Internal Revenue Code, section 125, and that the parent is responsible for paying the taxes owed on the amount reimbursed.

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

Sec. 10. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 11. **Annual review; written notice.** (a) The commissioner must review the monthly contribution amount at least once every 12 months and when there is a change in household size or there is a loss of or gain in income from one month to another in excess of ten percent.

(b) The local agency must mail a written notice 30 days in advance of the effective date of a change in the contribution amount. A decrease in the contribution amount is effective in the month that the parent verifies a reduction in income or change in household size.

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

Sec. 11. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 12. **Parents who do not live with each other; contribution.** Parents of a minor child who do not live with each other must each pay the contribution required under subdivision 8. The commissioner must deduct an amount equal to the annual court-ordered child support payment actually paid on behalf of the child receiving services from the adjusted gross income of the parent making the payment before calculating the parental contribution under subdivision 8.

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

Sec. 12. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 13. **Parents with more than one child receiving services; contribution.** The commissioner must not require parents who have more than one child receiving services to pay more than the amount for the child with the highest expenditures. The commissioner must not require the parent to pay a contribution in excess of the cost of the services provided to the child, not counting payments made to school districts for education-related services.

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

Sec. 13. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 14. **Insurance coverage.** (a) The commissioner must increase the contribution under subdivision 8 by an additional five percent if the local agency determines that insurance coverage is available but not obtained for the child.

(b) For purposes of this subdivision, "available" means insurance that is a benefit of employment for a family member at an annual cost of no more than five percent of the family's annual income.

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

Sec. 14. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 15. **Contribution reduction.** (a) The commissioner must reduce the contribution under subdivision 8 by $300 per fiscal year if in the 12 months before July 1:

(1) the parent applied for insurance for the child;

(2) the insurer denied insurance;

(3) the parents submitted a complaint or appeal in writing to the insurer, submitted a complaint or appeal in writing to the commissioner of health or the commissioner of commerce, or litigated the complaint or appeal; and

(4) as a result of the dispute, the insurer reversed its decision and granted insurance.

(b) A parent who requests a reduction in the contribution amount under this subdivision must submit proof in the form and manner prescribed by the commissioner or local agency, including but not limited to the insurer's denial of insurance, the written letter or complaint of the parents, court documents, and the written response of the insurer approving insurance. The determinations of the commissioner or local agency under this subdivision are not rules subject to chapter 14.

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

Sec. 15. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 16. **Civil actions.** If a parent fails to make appropriate reimbursement as required in subdivisions 7 and 8, the attorney general, at the request of the commissioner, may institute

or direct the appropriate county attorney to institute civil action to recover the required reimbursement.

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

Sec. 16. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 17. **Order of payment.** If the parental contribution is for reimbursement for the cost of services to both the local agency and the medical assistance program, the local agency must be reimbursed for the local agency's expenses first and the remainder must be deposited in the medical assistance account.

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

Sec. 17. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 18. **Determination; redetermination; notice.** The commissioner must mail a determination order and written notice of parental fee to the parent at least annually, or more frequently as provided in Minnesota Rules, parts 9550.6220 to 9550.6229. The determination order and notice must contain the following information:

(1) the amount the parent is required to contribute;

(2) notice of the right to a redetermination and appeal; and

(3) the telephone number of the division at the department that is responsible for redeterminations.

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

Sec. 18. Minnesota Statutes 2024, section 252.27, is amended by adding a subdivision to read:

Subd. 19. **Appeals.** (a) A parent may appeal the determination or redetermination of an obligation to make a contribution under this section according to section 256.045. The parent must make a request for a hearing in writing within 30 days of the date the commissioner mails the determination or redetermination order or within 90 days of the written notice if the parent shows good cause why the request was not submitted within the 30-day time limit. The commissioner must provide the parent with a written notice that acknowledges receipt of the request and notifies the parent of the date of the hearing. While the appeal is

pending, the parent has the rights regarding making payment that are provided in Minnesota Rules, part 9550.6235.

(b) If the commissioner's determination or redetermination is affirmed, the parent must within 90 calendar days after the date an order is issued under section 256.045, subdivision 5, pay the total amount due from the effective date of the notice of determination or redetermination that was appealed by the parent. If the commissioner's order under this subdivision results in a decrease in the parental fee amount, the commissioner must credit any payments made by the parent that result in an overpayment to the parent as provided in Minnesota Rules, part 9550.6235, subpart 3.

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

Sec. 19. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to read:

Subd. 45. **Health care eligibility oversight unit.** (a) The commissioner shall establish and maintain a Department of Human Services health care eligibility oversight unit responsible for collaboration at a regional level to ensure federal and state Medicaid eligibility requirements are consistently applied by all processing entities.

(b) The oversight unit must monitor compliance, identify systemic issues, and provide guidance and technical assistance to lead agencies.

(c) The commissioner shall require lead agencies to work directly with the oversight unit on corrective action planning and implementation to achieve compliance and strengthen performance outcomes.

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

Sec. 20. Minnesota Statutes 2025 Supplement, section 256.9657, subdivision 2b, is amended to read:

Subd. 2b. **Hospital assessment.** (a) For purposes of this subdivision, the following terms have the meanings given:

(1) "eligible hospital" means:

(i) PrairieCare psychiatric hospital; or

(ii) a hospital licensed under section 144.50, located in Minnesota, and with a Medicare cost report filed and showing in the Healthcare Cost Report Information System (HCRIS), except for the following:

(A) federal Indian Health Service facilities;

(B) state-owned or state-operated regional treatment centers and all state-operated services;

(C) federal Veterans Administration Medical Centers; ~~and~~

(D) long-term acute care hospitals; and

(E) hospitals that do not receive payments under section 256B.1974;

(2) "net outpatient revenue" means total outpatient revenue less Medicare revenue as calculated from:

(i) values on Worksheet G of the hospital's Medicare cost report; or

(ii) for PrairieCare psychiatric hospital, data available to the commissioner; and

(3) "total patient days" means total hospital inpatient days as reported on:

(i) Worksheet S-3 of the hospital's Medicare cost report; or

(ii) for PrairieCare psychiatric hospital, data available to the commissioner.

(b) Subject to paragraphs (m) to (o), each eligible hospital must pay assessments to the hospital directed payment program account in the special revenue fund, with an aggregate annual assessment amount equal to the sum of the following:

(1) $120.22 multiplied by total patient days; and

(2) 5.96 percent of the hospital's net outpatient revenue.

(c) The assessment amount for calendar years 2026 and 2027 must be based on the total patient days and net outpatient revenue reflected on an eligible hospital's Medicare cost report as follows:

(1) an eligible hospital with a fiscal year ending on March 31 or June 30 must use data from a cost report from the hospital's fiscal year 2022; and

(2) an eligible hospital with a fiscal year ending on September 30 or December 31 must use data from a cost report from the hospital's fiscal year 2021.

(d) The annual assessment amount for calendar years after 2027 must be set for a two-year period and must be based on the total patient days and net outpatient revenue reflected on an eligible hospital's most recent Medicare cost report filed and showing in HCRIS as of August 1 of the year prior to the subsequent two-year period.

(e) The commissioner may, after consultation with the Minnesota Hospital Association, modify the rates of assessment in paragraph (b) as necessary to comply with federal law, obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or otherwise maximize under this section federal financial participation for medical assistance. Notwithstanding the foregoing authorization to maximize federal financial participation for medical assistance, the commissioner must reduce the rates of assessment in paragraph (b) as necessary to ensure:

(1) the state's aggregated health care-related taxes on inpatient hospital services do not exceed 5.75 percent of the net patient revenue attributable to those services; and

(2) the state's aggregated health care-related taxes on outpatient hospital services do not exceed 5.75 percent of the net patient revenue attributable to those services.

(f) Eligible hospitals must pay the annual assessment amount under paragraph (b) to the commissioner by paying four equal, quarterly assessments. Eligible hospitals must pay the quarterly assessments by January 1, April 1, July 1, and October 1 each year. Assessments must be paid in the form and manner specified by the commissioner. An eligible hospital is prohibited from paying a quarterly assessment until the eligible hospital has received the applicable invoice under paragraph (g).

(g) The commissioner must provide eligible hospitals with an invoice by December 1 for the assessment due January 1, March 1 for the assessment due April 1, June 1 for the assessment due July 1, and September 1 for the assessment due October 1 each year.

(h) The commissioner must notify each eligible hospital of the hospital's estimated annual assessment amount for the subsequent calendar year by October 15 each year.

(i) If any of the dates for assessments or invoices in paragraphs (f) to (h) fall on a holiday, the applicable date is the next business day.

(j) A hospital that has merged with another hospital must have the surviving hospital's assessment revised at the start of the hospital's first full fiscal year after the merger is complete. A closed hospital is retroactively responsible for assessments owed for services provided through the final date of operations.

(k) If the commissioner determines that a hospital has underpaid or overpaid an assessment, the commissioner must notify the hospital of the unpaid assessment or of any refund due. The commissioner must refund a hospital's overpayment from the hospital directed payment program account created in section 256B.1975, subdivision 1.

(l) Revenue from an assessment under this subdivision must only be used by the commissioner to pay the nonfederal share of the directed payment program under section 256B.1974.

(m) The commissioner is prohibited from collecting any assessment under this subdivision during any period of time when:

(1) federal financial participation is unavailable or disallowed, or if the approved aggregate federal financial participation for the directed payment under section 256B.1974 is less than 51 percent; or

(2) a directed payment under section 256B.1974 is not approved by the Centers for Medicare and Medicaid Services.

(n) The commissioner must make the following discounts from the inpatient portion of the assessment under paragraph (b), clause (1), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) Hennepin Healthcare, with a discount of 25 percent;

(2) Mayo Rochester, with a discount of ten percent;

(3) Gillette Children's Hospital, with a discount of 90 percent;

(4) each hospital not included in another discount category, and with greater than $200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service and managed care, as reported in state fiscal year 2022 medical assistance fee-for-service and managed care claims data, with a discount of five percent; and

(5) any hospital responsible for greater than 12 percent of the total assessment annually collected statewide, with a discount in the amount necessary such that the hospital is responsible for 12 percent of the total assessment annually collected statewide.

(o) The commissioner must make the following discounts from the outpatient portion of the assessment under paragraph (b), clause (2), in the stated amount or as necessary to achieve federal approval of the assessment in this section:

(1) each critical access hospital or independent hospital located outside a city of the first class and paid under the Medicare prospective payment system, with a discount of 40 percent;

(2) Gillette Children's Hospital, with a discount of 90 percent;

(3) Hennepin Healthcare, with a discount of 60 percent;

(4) Mayo Rochester, with a discount of 20 percent; and

(5) each hospital not included in another discount category, and with greater than $200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service and managed care, as reported in state fiscal year 2022 medical assistance fee-for-service and managed care claims data, with a discount of ten percent.

(p) If the federal share of the hospital directed payment program under section 256B.1974 is increased as the result of an increase to the federal medical assistance percentage, the commissioner must reduce the assessment on a uniform percentage basis across eligible hospitals on which the assessment is imposed, such that the aggregate amount collected from hospitals under this subdivision does not exceed the total amount needed to maintain the same aggregate state and federal funding level for the directed payments authorized by section 256B.1974.

(q) Eligible hospitals must submit to the commissioner on an annual basis, in the form and manner specified by the commissioner in consultation with the Minnesota Hospital Association, all documentation necessary to determine the assessment amounts under this subdivision.

EFFECTIVE DATE. This section is effective upon the date that Laws 2025, First Special Session chapter 3, article 8, section 4, becomes effective.

Sec. 21. Minnesota Statutes 2025 Supplement, section 256.969, subdivision 2f, is amended to read:

Subd. 2f. **Alternate inpatient payment rate.** (a) Effective January 1, 2022, for a hospital eligible to receive disproportionate share hospital payments under subdivision 9, paragraph (d), clause (6), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), clause (6), by ~~99~~ one percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received the entire amount calculated under subdivision 9, paragraph (d), clause (6). This paragraph expires when paragraph (b) becomes effective.

(b) For hospitals eligible to receive payment under section 256B.1973 or 256B.1974 and meeting the criteria in subdivision 9, paragraph (d), the commissioner ~~must~~ may reduce the amount calculated under subdivision 9, paragraph (d), by one percent and compute an alternate inpatient payment rate. The alternate payment rate must be structured to target a total aggregate reimbursement amount equal to the amount that the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled

in medical assistance had the hospital received 99 percent of the entire amount calculated under subdivision 9, paragraph (d). Hospitals that do not meet federal requirements for Medicaid disproportionate share hospitals are not eligible for the alternate payment rate.

EFFECTIVE DATE. This section is effective upon the date that Laws 2025, First Special Session chapter 3, article 8, section 5, becomes effective.

Sec. 22. Minnesota Statutes 2024, section 256B.04, subdivision 27, is amended to read:

Subd. 27. **Disenrollment under medical assistance and MinnesotaCare.** (a) The commissioner shall regularly obtain and use information from reliable data sources, including but not limited to managed care and county-based purchasing plans, state health and human services programs, mail returned by the United States Postal Service with a forwarding address, and the National Change of Address database maintained by the United States Postal Service, to update mailing addresses and other contact information for medical assistance and MinnesotaCare enrollees ~~in cases of returned mail and nonresponse using information available through managed care and county-based purchasing plans, state health and human services programs, and other sources~~.

(b) The commissioner shall not disenroll an individual from medical assistance or MinnesotaCare in cases of returned mail until the commissioner makes at least two attempts by phone, email, or other methods to contact the individual. The commissioner may disenroll the individual after providing no less than 30 days for the individual to respond to the most recent contact attempt.

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

Sec. 23. Minnesota Statutes 2024, section 256B.056, subdivision 1, is amended to read:

Subdivision 1. **Residency.** (a) To be eligible for medical assistance, a person must reside in Minnesota, or, if absent from the state, be deemed to be a resident of Minnesota, in accordance with Code of Federal Regulations, title 42, section 435.403. A child who is placed in Minnesota in a family foster home, as defined in section 260C.007, subdivision 16b, by another state is a Minnesota resident, in accordance with Minnesota's interstate agreements and Code of Federal Regulations, title 42, section 435.403(k).

(b) The commissioner shall identify individuals who are enrolled in medical assistance and who are absent from the state for more than 30 consecutive days, but who continue to qualify for medical assistance in accordance with paragraph (a).

(c) If the individual is absent from the state for more than 30 consecutive days but still deemed a resident of Minnesota in accordance with paragraph (a), any covered service provided to the individual must be paid through the fee-for-service system and not through the managed care capitated rate payment system under section 256B.69 or 256L.12.

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

Sec. 24. Minnesota Statutes 2024, section 256B.056, subdivision 2a, is amended to read:

Subd. 2a. **Home equity limit for medical assistance payment of long-term care services.** (a) Effective for requests of medical assistance payment of long-term care services filed on or after July 1, 2006, and for renewals on or after July 1, 2006, for persons who received payment of long-term care services under a request filed on or after January 1, 2006, the equity interest in the home of a person whose eligibility for long-term care services is determined on or after January 1, 2006, shall not exceed $500,000, unless it is the lawful residence of the person's spouse or child who is under age 21, or a child of any age who is blind or permanently and totally disabled as defined in the Supplemental Security Income program. The amount specified in this paragraph shall be increased beginning in year 2011, from year to year based on the percentage increase in the Consumer Price Index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

(b) Effective January 1, 2028, the amount specified in paragraph (a) must not exceed $1,000,000.

~~(b)~~ (c) For purposes of this subdivision, a "home" means any real or personal property interest, including an interest in an agricultural homestead as defined under section 273.124, subdivision 1, that, at the time of the request for medical assistance payment of long-term care services, is the primary dwelling of the person or was the primary dwelling of the person before receipt of long-term care services began outside of the home.

~~(c)~~ (d) A person denied or terminated from medical assistance payment of long-term care services because the person's home equity exceeds the home equity limit may seek a waiver based upon a hardship by filing a written request with the county agency. Hardship is an imminent threat to the person's health and well-being that is demonstrated by documentation of no alternatives for payment of long-term care services. The county agency shall make a decision regarding the written request to waive the home equity limit within 30 days if all necessary information has been provided. The county agency shall send the person and the person's representative a written notice of decision on the request for a demonstrated hardship waiver that also advises the person of appeal rights under the fair hearing process of section 256.045.

Sec. 25. Minnesota Statutes 2024, section 256B.056, subdivision 3d, is amended to read:

Subd. 3d. **Reduction of excess assets.** Assets in excess of the limits in subdivisions 3 to 3c may be reduced to allowable limits as follows:

(a) Assets may be reduced in ~~any~~ either of the ~~three~~ two calendar months before the month of application in which the applicant seeks coverage according to section 256B.061 by paying bills for health services that are incurred in the retroactive period for which the applicant seeks eligibility, starting with the oldest bill. After assets are reduced to allowable limits, eligibility begins with the next dollar of MA-covered health services incurred in the retroactive period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.

(b) Assets may be reduced beginning the month of application by paying bills for health services that are incurred during the period specified in Minnesota Rules, part 9505.0090, subpart 2, that would otherwise be paid by medical assistance. After assets are reduced to allowable limits, eligibility begins with the next dollar of medical assistance covered health services incurred in the period. Applicants reducing assets under this subdivision who also have excess income shall first spend excess assets to pay health service bills and may meet the income spenddown on remaining bills.

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

Sec. 26. Minnesota Statutes 2024, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application and for ~~three~~ either one or two months prior to application if the person was eligible in those prior months in accordance with section 256B.061. ~~A redetermination of eligibility must occur every 12 months.~~

(b) Notwithstanding any other law to the contrary:

(1) a child under 19 years of age who is determined eligible for medical assistance must remain eligible for a period of 12 months;

(2) a child 19 years of age and older but under 21 years of age who is determined eligible for medical assistance must remain eligible for a period of 12 months; and

(3) a child under six years of age who is determined eligible for medical assistance must remain eligible through the month in which the child reaches six years of age.

(c) A child's eligibility under paragraph (b) may be terminated earlier if:

(1) the child or the child's representative requests voluntary termination of eligibility;

(2) the child ceases to be a resident of this state;

(3) the child dies;

(4) the child attains the maximum age; or

(5) the agency determines eligibility was erroneously granted at the most recent eligibility determination due to agency error or fraud, abuse, or perjury attributed to the child or the child's representative.

(d) For a person eligible for an insurance affordability program as defined in section 256B.02, subdivision 19, who reports a change that makes the person eligible for medical assistance other than under section 256B.055, subdivision 15, eligibility is available for the month the change was reported and for ~~three~~ two months prior to the month the change was reported, if the person was eligible in those prior months. If the change makes the person eligible for medical assistance under section 256B.055, subdivision 15, eligibility is available for the month the change was reported and for one month prior to the month the change was reported if the person was eligible in that prior month.

(e) The period of eligibility for a person eligible for medical assistance under section 256B.055, subdivision 15, is six months. The period of eligibility for all other medical assistance enrollees is 12 months.

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

Sec. 27. Minnesota Statutes 2024, section 256B.056, subdivision 7a, is amended to read:

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

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

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

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

(e) Notwithstanding paragraph (a), a person who is eligible under section 256B.055, subdivision 15, and who is not an American Indian or Alaska Native is subject to a redetermination of eligibility every six months.

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

Sec. 28. Minnesota Statutes 2024, section 256B.0561, subdivision 2, is amended to read:

Subd. 2. **Periodic data matching.** (a) The commissioner shall conduct periodic data matching to identify recipients who, based on available electronic data, may not meet eligibility criteria for the public health care program in which the recipient is enrolled. The commissioner shall conduct data matching for medical assistance or MinnesotaCare recipients at least once during a recipient's 12-month period of eligibility, except as provided in paragraph (f).

(b) If data matching indicates a recipient may no longer qualify for medical assistance or MinnesotaCare, the commissioner must notify the recipient and allow the recipient no more than 30 days to confirm the information obtained through the periodic data matching or provide a reasonable explanation for the discrepancy to the state or county agency directly responsible for the recipient's case. If a recipient does not respond within the advance notice period or does not respond with information that demonstrates eligibility or provides a reasonable explanation for the discrepancy within the 30-day time period, the commissioner shall terminate the recipient's eligibility in the manner provided for by the laws and regulations governing the health care program for which the recipient has been identified as being ineligible.

(c) The commissioner shall not terminate eligibility for a recipient who is cooperating with the requirements of paragraph (b) and needs additional time to provide information in response to the notification.

(d) A recipient whose eligibility was terminated according to paragraph (b) may be eligible for medical assistance no earlier than the first day of the month in which the recipient provides information that demonstrates the recipient's eligibility.

(e) Any termination of eligibility for benefits under this section may be appealed as provided for in sections 256.045 to 256.0451, and the laws governing the health care programs for which eligibility is terminated.

(f) Effective January 1, 2027, a person receiving medical assistance under section 256B.055, subdivision 15, who is subject to a redetermination of eligibility every six months under section 256B.056, subdivision 7a, paragraph (e), is exempt from periodic data matching under this subdivision.

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

Sec. 29. **[256B.0562] WORK OR COMMUNITY ENGAGEMENT REQUIREMENTS.**

Subdivision 1. **Medical assistance eligibility requirement.** (a) To be eligible for medical assistance under section 256B.055, subdivision 15, a person must either demonstrate work or community engagement or meet an exemption in accordance with section 71119 of the One Big Beautiful Bill Act, Public Law 119-21.

(b) An applicant must meet the requirements of this section for the month immediately preceding the month during which the person submits an application for medical assistance.

(c) To renew eligibility pursuant to section 256B.056, subdivision 7a, a person enrolled and receiving medical assistance must meet the requirements of this section for at least one month during the person's six-month period of eligibility.

Subd. 2. **Compliance and exemptions.** (a) A person demonstrates work or community engagement under this section for a given month if the person meets at least one of the following conditions with respect to that month:

(1) the person works at least 80 hours;

(2) the person completes at least 80 hours of community service;

(3) the person participates in a work program for at least 80 hours;

(4) the person is enrolled in an educational program at least half time;

(5) the person engages in any combination of the activities in clauses (1) to (4) for a total of at least 80 hours;

(6) the person has a monthly income that is not less than the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938, multiplied by 80 hours; or

(7) the person has an average monthly income during the preceding six months that is equal to or greater than the applicable minimum wage requirement under section 6 of the Fair Labor Standards Act of 1938, multiplied by 80 hours and is a seasonal worker, as defined in section 45R(d)(5)(B) of the Internal Revenue Code of 1986.

(b) A person is exempt from the requirement to demonstrate work or community engagement if the person:

(1) is an American Indian or Alaska Native;

(2) is a family caregiver, as defined in section 2 of the RAISE Family Caregivers Act, of a disabled individual;

(3) is a veteran with a disability rated as total under United States Code, title 38, section 1155;

(4) is medically frail or has special medical needs, including a person who:

(i) is blind or disabled, as defined in section 1614 of the Social Security Act;

(ii) has a substance use disorder;

(iii) has a disabling mental disorder;

(iv) has a physical, intellectual, or developmental disability that significantly impairs the person's ability to perform daily living routines; or

(v) has a serious or complex medical condition;

(5) meets the work requirements imposed by the Minnesota family investment program;

(6) is a member of a household that receives Supplemental Nutrition Assistance Program benefits and is not exempt from the requirements of section 142F.10;

(7) is participating in a drug addiction or alcoholic treatment and rehabilitation program; or

(8) is incarcerated.

(c) A person is exempt from the requirement to demonstrate work or community engagement for a given month if for part or all of that month the person is:

(1) described in paragraph (b);

(2) under 21 years of age;

(3) entitled to or enrolled in benefits under Medicare Part A or enrolled in benefits under Medicare Part B;

(4) enrolled in medical assistance under an eligibility category other than section 256B.055, subdivision 15; or

(5) incarcerated at any point during the three-month period ending on the first day of the given month.

Subd. 3. **Short-term hardship events.** (a) The commissioner shall seek any approvals necessary from the federal Secretary of Health and Human Services to implement the short-term hardship exemptions described in this subdivision.

(b) A person is exempt from the requirement to demonstrate work or community engagement for a given month if the person experiences a short-term hardship event for part or all of that month.

(c) For purposes of this section, "short-term hardship event" means an event in which a person:

(1) receives inpatient hospital or nursing facility services, services in an intermediate care facility for individuals with intellectual disabilities, inpatient psychiatric hospital services, or other services of similar acuity;

(2) resides in a county in which there is an emergency or disaster declared by the President of the United States pursuant to the National Emergencies Act or the Robert T. Stafford Disaster Relief and Emergency Assistance Act;

(3) resides in a county that has an unemployment rate at or above the lesser of eight percent or 1.5 times the national unemployment rate; or

(4) must travel outside of the person's community for an extended period of time to receive medical services that are not available within the community of residence necessary to treat a serious or complex medical condition of the person or the person's dependent.

(d) A person must request the short-term hardship event exceptions described in paragraph (c), clauses (1) and (4), to be granted the exception.

Subd. 4. **Noncompliance procedure.** (a) Before denying or terminating medical assistance eligibility for failure to demonstrate work or community engagement or meet an exemption, the commissioner must provide an applicant or enrollee:

(1) a notice of noncompliance; and

(2) a period of 30 calendar days to provide evidence of compliance or exemption from the requirement.

(b) The commissioner must continue to provide medical assistance to an enrollee during the 30-day period under paragraph (a), clause (2). If the person does not provide evidence of compliance or exemption from the requirement within the 30-day period, the commissioner must deny the application or terminate eligibility by the end of the month following the month in which the 30-day period ends.

(c) Before denial or termination of eligibility, the commissioner must:

(1) provide the person with advance notice in accordance with Code of Federal Regulations, title 42, section 431.211; and

(2) determine whether the person may qualify for medical assistance under any other eligibility category.

Subd. 5. **Expedited rulemaking authority.** The commissioner may adopt rules necessary to implement and administer this section using the expedited rulemaking process under section 14.389. The 18-month time limit under section 14.125 does not apply to the rulemaking authority under this section.

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

Sec. 30. Minnesota Statutes 2024, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

(b) "Qualified noncitizen" means a person who meets one of the following immigration criteria:

(1) admitted for lawful permanent residence according to United States Code, title 8;

(2) admitted to the United States as a refugee according to United States Code, title 8, section 1157;

(3) granted asylum according to United States Code, title 8, section 1158;

(4) granted withholding of deportation according to United States Code, title 8, section 1253(h);

(5) paroled for a period of at least one year according to United States Code, title 8, section 1182(d)(5);

(6) granted conditional entrant status according to United States Code, title 8, section 1153(a)(7);

(7) determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V of the Omnibus Consolidated Appropriations Bill, Public Law 104-200;

(8) is a child of a noncitizen determined to be a battered noncitizen by the United States Attorney General according to the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, title V, of the Omnibus Consolidated Appropriations Bill, Public Law 104-200; or

(9) determined to be a Cuban or Haitian entrant as defined in section 501(e) of Public Law 96-422, the Refugee Education Assistance Act of 1980.

(c) All qualified noncitizens who were residing in the United States before August 22, 1996, who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation.

(d) Beginning December 1, 1996, qualified noncitizens who entered the United States on or after August 22, 1996, and who otherwise meet the eligibility requirements of this chapter are eligible for medical assistance with federal participation for five years if they meet one of the following criteria:

(1) refugees admitted to the United States according to United States Code, title 8, section 1157;

(2) persons granted asylum according to United States Code, title 8, section 1158;

(3) persons granted withholding of deportation according to United States Code, title 8, section 1253(h);

(4) veterans of the United States armed forces with an honorable discharge for a reason other than noncitizen status, their spouses and unmarried minor dependent children; or

(5) persons on active duty in the United States armed forces, other than for training, their spouses and unmarried minor dependent children.

Beginning July 1, 2010, children and pregnant women who are noncitizens described in paragraph (b) or who are lawfully present in the United States as defined in Code of Federal Regulations, title 8, section 103.12, and who otherwise meet eligibility requirements of this chapter, are eligible for medical assistance with federal financial participation as provided by the federal Children's Health Insurance Program Reauthorization Act of 2009, Public Law 111-3.

(e) Nonimmigrants who otherwise meet the eligibility requirements of this chapter are eligible for the benefits as provided in paragraphs (f) to (h). For purposes of this subdivision, a "nonimmigrant" is a person in one of the classes listed in United States Code, title 8, section 1101(a)(15).

(f) Payment shall also be made for care and services that are furnished to noncitizens, regardless of immigration status, who otherwise meet the eligibility requirements of this chapter, if such care and services are necessary for the treatment of an emergency medical condition.

(g) For purposes of this subdivision, the term "emergency medical condition" means a medical condition that meets the requirements of United States Code, title 42, section 1396b(v).

(h)(1) Notwithstanding paragraph (g), services that are necessary for the treatment of an emergency medical condition are limited to the following:

(i) services delivered in an emergency room or by an ambulance service licensed under chapter 144E that are directly related to the treatment of an emergency medical condition;

(ii) services delivered in an inpatient hospital setting following admission from an emergency room or clinic for an acute emergency condition; and

(iii) follow-up services that are directly related to the original service provided to treat the emergency medical condition and are covered by the global payment made to the provider.

(2) Services for the treatment of emergency medical conditions do not include:

(i) services delivered in an emergency room or inpatient setting to treat a nonemergency condition;

(ii) organ transplants, stem cell transplants, and related care;

(iii) services for routine prenatal care;

(iv) continuing care, including long-term care, nursing facility services, home health care, adult day care, day training, or supportive living services;

(v) elective surgery;

(vi) outpatient prescription drugs, unless the drugs are administered or dispensed as part of an emergency room visit;

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

(xii) prosthetics, orthotics, durable medical equipment, or medical supplies;

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) substance use disorder treatment.

(i) Pregnant noncitizens who are ineligible for federally funded medical assistance because of immigration status, are not covered by a group health plan or health insurance coverage according to Code of Federal Regulations, title 42, section 457.310, and who otherwise meet the eligibility requirements of this chapter, are eligible for medical assistance through the period of pregnancy, including labor and delivery, and 12 months postpartum.

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal

financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

(k) Notwithstanding paragraph (h), clause (2), the following services are covered as emergency medical conditions under paragraph (f) except where coverage is prohibited under federal law for services under clauses (1) and (2):

(1) dialysis services provided in a hospital or freestanding dialysis facility;

(2) surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer if the recipient has a cancer diagnosis that is not in remission and requires surgery, chemotherapy, or radiation treatment; and

(3) kidney transplant if the person has been diagnosed with end stage renal disease, is currently receiving dialysis services, and is a potential candidate for a kidney transplant.

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under chapter 256S, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

(m) Notwithstanding paragraph (i), medical assistance is only available to noncitizens who are eligible for coverage with federal financial participation provided by Medicaid or the Children's Health Insurance Program.

Sec. 31. Minnesota Statutes 2024, section 256B.061, is amended to read:

256B.061 ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS.

(a) If an individual is determined to be eligible for medical assistance under section 256B.055, subdivision 15, medical assistance is available for care and services included under the plan and furnished in or after the month before the month in which the individual made application for the assistance if the individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished.

(b) If ~~any~~ an individual has been determined to be eligible for medical assistance other than under section 256B.055, subdivision 15, ~~it will be made~~ medical assistance is available for care and services included under the plan and furnished in or after the ~~third~~ second month before the month in which the individual made application for ~~such~~ the assistance~~,~~ if ~~such~~ the individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished.

(c) The commissioner may limit, restrict, or suspend the eligibility of an individual for up to one year upon that individual's conviction of a criminal offense related to application for or receipt of medical assistance benefits.

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

Sec. 32. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 20, is amended to read:

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

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

(c) Medical assistance and MinnesotaCare payment for mental health case management ~~shall~~ must be made ~~on a monthly basis~~ in accordance with section 256B.076, subdivisions 1, 2, 5, and 7. ~~In order to receive payment for an eligible child, the provider must document~~

~~at least a face-to-face contact either in person or by interactive video that meets the requirements of subdivision 20b with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:~~

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

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

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

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

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

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

(h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for mental health case management shall be provided by the recipient's county of responsibility,

as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds used to match other federal funds. If the service is provided by a tribal agency, the nonfederal share, if any, shall be provided by the recipient's tribe. When this service is paid by the state without a federal share through fee-for-service, 50 percent of the cost shall be provided by the recipient's county of responsibility.

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

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

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

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

(2) programming the information systems.

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

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

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

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

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

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

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

(q) Counties may receive payment for up to 12 15-minute units for use at case initiation and case closing to facilitate the case management client's needs assessments, individualized plan development, referrals, or case documentation without needing to meet the contact requirements specified in sections 245.4711, 245.4881, 256B.0924, 256B.094, and 256F.10.

Sec. 33. Minnesota Statutes 2024, section 256B.0631, subdivision 1a, is amended to read:

Subd. 1a. **Prohibition on cost-sharing and deductibles.** ~~Effective January 1, 2024~~ Except for recipients eligible under section 256B.055, subdivision 15, the medical assistance benefit plan must not include cost-sharing or deductibles for any medical assistance recipient or benefit.

Sec. 34. Minnesota Statutes 2024, section 256B.0631, is amended by adding a subdivision to read:

Subd. 5. **Cost sharing.** (a) Effective on or after October 1, 2028, except as provided in subdivision 6, the medical assistance benefit plan includes the following cost sharing for recipients eligible under section 256B.055, subdivision 15, with income above 100 percent of the federal poverty level:

(1) $3 per nonpreventive visit, except as provided in paragraph (c). For purposes of this subdivision, a visit means an episode of service that is required because of a recipient's symptoms, diagnosis, or established illness, and that is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room; and

(3) $3 per brand-name drug prescription, $1 per generic drug prescription, and $1 per prescription for a brand-name multisource drug listed in preferred status on the preferred drug list, subject to a $12 maximum per month for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(b) Cost sharing for prescription drugs and related medical supplies to treat chronic disease must comply with the requirements of section 62Q.481.

(c) A person eligible for medical assistance under section 256B.055, subdivision 15, is responsible for all co-payments and deductibles in this subdivision.

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

Sec. 35. Minnesota Statutes 2024, section 256B.0631, is amended by adding a subdivision to read:

Subd. 6. **Exceptions.** Co-payments and deductibles are subject to the exceptions and limits required by section 71120 of the One Big Beautiful Bill Act, Public Law 119-21.

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

Sec. 36. Minnesota Statutes 2024, section 256B.0631, is amended by adding a subdivision to read:

Subd. 7. **Collection.** (a) The medical assistance reimbursement to the provider must be reduced by the amount of the co-payment or deductible, except that reimbursements must not be reduced:

(1) once a recipient has reached the $12 maximum per month for prescription drug co-payments; or

(2) for a recipient who has met the recipient's monthly five percent cost-sharing limit.

(b) The provider collects the co-payment or deductible from the recipient. Providers must not deny services to recipients who are unable to pay the co-payment or deductible.

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

Sec. 37. Minnesota Statutes 2024, section 256B.076, subdivision 1, is amended to read:

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

(b) The commissioner, in collaboration with Tribes, counties, providers, and individuals served, must propose further modifications to targeted case management services to ensure

a program that complies with all federal requirements, delivers services in a cost-effective and efficient manner, creates uniform expectations for targeted case management services, addresses health disparities, and promotes person- and family-centered services.

(c) The commissioner may suspend, reduce, or terminate the reimbursement to a provider that does not meet the requirements of this section or sections 245.4711, 245.4881, 256B.0625, subdivisions 20 and 20b, 256B.0924, 256B.094, and 256F.10. The county of financial responsibility, as determined under sections 256G.01 to 256G.12 or, if applicable, the Tribal agency, is responsible for any federal disallowances. The county or Tribal agency may share the financial responsibility with the county's or Tribal agency's contracted vendors.

Sec. 38. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision to read:

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

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

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

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

(e) Upon implementation, the commissioner must base interim rates on data from the testing period. The commissioner must base subsequent interim rates for a calendar year

on the most recently completed reconciliation. The commissioner must notify counties of the interim rate by June 30 each year and post interim rates publicly. If the commissioner is unable to notify the counties by June 30, the commissioner must notify each county in writing no later than June 30 that the new interim rate is delayed and must provide an estimate of when the new interim rate will be available.

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

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

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

Sec. 39. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision to read:

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

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

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

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

Sec. 40. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision to read:

Subd. 7. **Managed care plan units and rates for mental health targeted case management.** The commissioner must ensure that the prepaid health plans providing covered health services for eligible persons pursuant to this chapter and chapter 256L reimburse

counties at a rate that is at least equal to the fee-for-service rate described in subdivision 5 for targeted case management services provided to Minnesota health care program (MHCP) health plan enrollees covered by medical assistance. If, for any contract year, federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this subdivision. Contracts between managed care plans and county-based purchasing plans and providers to whom this subdivision applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this subdivision. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision. This subdivision expires if federal approval is not received for this subdivision at any time. This subdivision does not obligate MHCP health plans to contract with counties for the provision of targeted case management services.

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

Sec. 41. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision to read:

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

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

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

for a given calendar year must not exceed two percent of statewide federal targeted case management federal reimbursement that calendar year.

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

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

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

Sec. 42. Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, is amended to read:

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

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

(c) Payment for targeted case management provided by county-contracted vendors shall be based on a monthly rate calculated in accordance with section 256B.076, subdivision 2. The rate must not exceed the rate charged by the vendor for the same service to other payers.

If the service is provided by a team of contracted vendors, the team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county, except to reimburse the county for advance funding provided by the county to the vendor.

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 43. Minnesota Statutes 2024, section 256B.094, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 44. Minnesota Statutes 2024, section 256B.094, subdivision 3, is amended to read:

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

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

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

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

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

Sec. 45. Minnesota Statutes 2024, section 256B.094, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

Sec. 46. Minnesota Statutes 2024, section 256B.094, subdivision 7, is amended to read:

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

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

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

(2) for a client placed outside of the county of financial responsibility, or a client served by Tribal social services placed outside the reservation, in an excluded time facility under section 256G.02, subdivision 6, or according to the Interstate Compact for the Placement

of Children under section 260.93, and the placement in either case is more than 60 miles beyond the county or reservation boundaries, there must be at least one contact per month and not more than two consecutive months without a face-to-face, in-person contact.

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

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

(1) the name of the recipient;

(2) the date of the service;

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

(4) the nature and extent of services; and

(5) the place of the services.

Sec. 47. Minnesota Statutes 2024, section 256B.14, subdivision 2, is amended to read:

Subd. 2. **Actions to obtain payment.** (a) The state agency shall promulgate rules to determine the ability of responsible relatives to contribute partial or complete payment or repayment of medical assistance furnished to recipients for whom they are responsible. All medical assistance exclusions shall be allowed, and a resource limit of $10,000 for nonexcluded resources shall be implemented. Above these limits, a contribution of one-third of the excess resources shall be required. These rules shall not require payment or repayment when payment would cause undue hardship to the responsible relative or that relative's immediate family. These rules ~~do not apply to~~ must be consistent with the requirements of section 252.27 for parents of children with household adjusted gross income equal to or greater than 675 percent of the federal poverty guidelines whose eligibility for medical assistance was determined without deeming of the parents' resources and income under the Tax Equity and Fiscal Responsibility Act (TEFRA) option or ~~to parents of children accessing~~ access home and community-based waiver services. The county agency shall give the responsible relative notice of the amount of the payment or repayment. If the state agency or county agency finds that notice of the payment obligation was given to the responsible relative, but that the relative failed or refused to pay, a cause of action exists against the responsible relative for that portion of medical assistance granted after notice was given to the responsible relative, which the relative was determined to be able to pay.

(b) The action may be brought by the state agency or the county agency in the county where assistance was granted, for the assistance, together with the costs of disbursements incurred due to the action.

(c) In addition to granting the county or state agency a money judgment, the court may, upon a motion or order to show cause, order continuing contributions by a responsible relative found able to repay the county or state agency. The order shall be effective only for the period of time during which the recipient receives medical assistance from the county or state agency.

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

Sec. 48. Minnesota Statutes 2025 Supplement, section 256B.1973, subdivision 9, is amended to read:

Subd. 9. **Interaction with other directed payments.** (a) An eligible provider under subdivision 3 may participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. A provider participating in the hospital directed payment program must not receive a directed payment under this section for any provider classes paid via the hospital directed payment program. A hospital subject to this section must notify the commissioner in writing no later than 30 days after enactment of this subdivision of the hospital's intention to participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both.

(b) The election under this subdivision is a onetime election, except that if an eligible provider elects to participate in the hospital directed payment program, and the hospital directed payment program expires or is not federally approved, the eligible provider may subsequently elect to participate in the directed payment under this section.

(c) If an eligible provider elects not to participate in the hospital directed payment program under section 256B.1974 and the federal statutes or regulations related to hospital directed payment programs are subsequently substantially changed, the eligible provider may elect to participate in the hospital directed payment program under section 256B.1974.

(d) The effective date of the election to participate in the hospital directed payment program under this section must align with the beginning of the calendar year in which payment rates under this section are updated. The eligible provider must notify the commissioner of the eligible provider's intention to make the election ten months before the effective date of the election.

Sec. 49. Minnesota Statutes 2024, section 256B.198, is amended to read:

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

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

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

(c) Effective July 1, 2013, or no earlier than 12 months after implementation of a total cost of care demonstration project, Hennepin County may receive federal matching funds for certified public expenditures under paragraph (a), if the county participates in a total cost of care demonstration project under sections 256B.0755 and 256B.0756, or another total cost of care demonstration project approved by the commissioner, and the county exceeds the minimum performance threshold established by the commissioner for the demonstration project. The value of the federal matching funds for the certified public expenditures allocated to Hennepin County shall be equal to the value of savings achieved above the minimum performance threshold. The same proportion of federal matching funds for certified public expenditure allocated to Hennepin County based on savings achieved under the demonstration project shall continue after the demonstration project and must continue to be paid to Hennepin County each year thereafter.

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

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

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

Sec. 50. Minnesota Statutes 2024, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

(a) For outpatient hospital facility fee payments for services rendered on or after October 1, 1992, the commissioner of human services shall pay the lower of (1) submitted charge, or (2) 32 percent above the rate in effect on June 30, 1992, except for those services for which there is a federal maximum allowable payment. Effective for services rendered on or after January 1, 2000, payment rates for nonsurgical outpatient hospital facility fees and emergency room facility fees shall be increased by eight percent over the rates in effect on December 31, 1999, except for those services for which there is a federal maximum allowable payment. Services for which there is a federal maximum allowable payment shall be paid at the lower of (1) submitted charge, or (2) the federal maximum allowable payment. Total aggregate payment for outpatient hospital facility fee services shall not exceed the Medicare upper limit. If it is determined that a provision of this section conflicts with existing or future requirements of the United States government with respect to federal financial participation in medical assistance, the federal requirements prevail. The commissioner may, in the aggregate, prospectively reduce payment rates to avoid reduced federal financial participation resulting from rates that are in excess of the Medicare upper limitations.

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics. Effective for services delivered on or after January 1, 2024, the rates paid to critical access hospitals under this section must be adjusted to include the

amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were not included in the rate adjustment described under section 256.969, subdivision 2b, paragraph (k).

(c) Critical access hospitals that convert to rural emergency hospitals in accordance with section 1861(kkk) of the Social Security Act must be paid the rate described in paragraph (b). The rate must be classified as either an outpatient hospital rate or a clinic rate as determined upon federal approval.

~~(c)~~ (d) Effective for services provided on or after July 1, 2003, rates that are based on the Medicare outpatient prospective payment system shall be replaced by a budget neutral prospective payment system that is derived using medical assistance data. The commissioner shall provide a proposal to the 2003 legislature to define and implement this provision. When implementing prospective payment methodologies, the commissioner shall use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for services delivered in outpatient hospital and ambulatory surgical center settings unless other payment methodologies for these services are specified in this chapter.

~~(d)~~ (e) For fee-for-service services provided on or after July 1, 2002, the total payment, before third-party liability and spenddown, made to hospitals for outpatient hospital facility services is reduced by .5 percent from the current statutory rate.

~~(e)~~ (f) In addition to the reduction in paragraph ~~(d)~~ (e), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

~~(f)~~ (g) In addition to the reductions in paragraphs ~~(d) and~~ (e) and (f), the total payment for fee-for-service services provided on or after July 1, 2008, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced three percent from the current statutory rates. Mental health services and facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

Sec. 51. Minnesota Statutes 2024, section 256L.04, subdivision 14, is amended to read:

Subd. 14. **Coordination with medical assistance.** (a) Individuals eligible for medical assistance under chapter 256B are not eligible for MinnesotaCare under this section.

(b) The commissioner shall coordinate eligibility and coverage to ensure that individuals transitioning between medical assistance and MinnesotaCare have seamless eligibility and access to health care services.

(c) Individuals denied or disenrolled from medical assistance for failure to comply with the eligibility requirements of section 256B.0562 are not eligible for MinnesotaCare.

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

Sec. 52. Minnesota Statutes 2024, section 295.52, subdivision 8, is amended to read:

Subd. 8. **Contingent reduction in tax rate.** (a) By December 1 of each year, beginning in 2011, the commissioner of management and budget shall determine the projected balance in the health care access fund for the biennium.

(b) If the commissioner of management and budget determines that the projected balance in the health care access fund for the biennium reflects a ratio of revenues to expenditures and transfers greater than 125 percent, and if the actual cash balance in the fund is adequate, as determined by the commissioner of management and budget, the commissioner, in consultation with the ~~commissioner~~ commissioners of revenue and human services, shall reduce the tax rates levied under subdivisions 1, 1a, 2, 3, and 4, for the subsequent calendar year sufficient to reduce the structural balance in the fund. The rate may be reduced to the extent that the projected revenues for the biennium do not exceed 125 percent of expenditures and transfers. The new rate shall be rounded to the nearest one-tenth of one percent. The rate reduction under this paragraph expires at the end of each calendar year and is subject to an annual redetermination by the commissioner of management and budget.

(c) For purposes of the analysis defined in paragraph (b), the commissioner of management and budget shall include projected revenues.

Sec. 53. **REPORT AND RECOMMENDATIONS ON FINANCIAL STABILITY OF SAFETY NET PROVIDERS.**

(a) The executive director of the Health Subcabinet, as established by Minnesota Statutes, section 4.047, in conjunction with member agencies and other state agencies, shall conduct a study to evaluate strategies to promote the long-term financial stability of safety net health care providers across Minnesota.

(b) The study must evaluate the current financial challenges facing safety net providers and consider changes that could be adopted by the state, local governments, and health care entities to promote sustainable access to essential health care services.

(c) For purposes of this section, "safety net provider" means:

(1) a hospital that accepts Medicare funding and is subject to section 1867 of the Social Security Act;

(2) a federally qualified health center, as defined in Minnesota Statutes, section 145.9269;

(3) a certified community behavioral health clinic, as defined in Minnesota Statutes, section 245.735; or

(4) a community mental health center, as defined in Minnesota Statutes, section 245.62, that provides uncompensated care.

(d) The executive director may contract with a vendor to support this study through research and actuarial analysis. Data from other state agencies must be made available for the purposes of this study as requested. The executive director is exempt from the requirements of Minnesota Statutes, chapters 16A and 16C, when entering into a new contract or amending an existing contract to complete analyses required under this section.

(e) By February 15, 2027, the executive director of the Health Subcabinet must report information from this section to the chairs and ranking minority members of the legislative committees with primary jurisdiction over health care policy and finance and health insurance.

ARTICLE 2
BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision to read:

Subd. 1a. **Direct payment.** For purposes of this section, "direct payment" means a funding mechanism used by the commissioner to distribute state appropriations to a county, Tribe, or other eligible governmental entity for the purpose of carrying out duties, services, or activities authorized under this section. A direct payment is not a grant under section 16B.97 and is not subject to statewide grant-making policies and laws, including but not limited to sections 16A.15 and 16C.05, except as specifically required by the commissioner. A direct payment must be used for the purposes and allowable activities established by the commissioner and is subject to financial oversight, reporting, and monitoring requirements under subdivision 11.

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

Sec. 2. Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision to read:

Subd. 3a. **Authority and rulemaking.** The commissioner may distribute money under this section through direct payments when the commissioner determines that a direct payment is the most effective and efficient method to support the delivery of adult mental health services, Tribal government activities, or county responsibilities under this section. The commissioner shall establish eligibility criteria, allowable uses, documentation standards, and reporting requirements for recipients of direct payments. The commissioner is authorized to engage in rulemaking to fulfill the requirements of this subdivision.

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

Sec. 3. Minnesota Statutes 2025 Supplement, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Programs and eligible services ~~and programs~~.** (a) The following three distinct ~~grant~~ programs ~~are funded~~ may receive direct payments under this section:

(1) mental health crisis services;

(2) housing with supports for adults with serious mental illness; and

(3) projects for assistance in transitioning from homelessness (PATH program).

(b) ~~In addition,~~ The following services are eligible for ~~grant funds~~ funding as direct payments under this section as the payor of last resort:

(1) community education and prevention;

(2) client outreach;

(3) early identification and intervention;

(4) adult outpatient diagnostic assessment and psychological testing;

(5) peer support services;

(6) community support program services (CSP);

(7) adult residential crisis stabilization;

(8) supported employment;

(9) assertive community treatment (ACT);

(10) housing subsidies;

(11) basic living, social skills, and community intervention;

(12) emergency response services;

(13) adult outpatient psychotherapy;

(14) adult outpatient medication management;

(15) adult mobile crisis services, including the purchase and renovation of vehicles by mobile crisis teams in order to provide protected transport under section 256B.0625, subdivision 17, paragraph (l), clause (6);

(16) adult day treatment;

(17) partial hospitalization;

(18) adult residential treatment;

(19) adult mental health targeted case management; and

(20) transportation.

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

Sec. 4. Minnesota Statutes 2024, section 245.4661, subdivision 10, is amended to read:

Subd. 10. **Commissioner duty to report on use of ~~grant~~ funds biennially.** (a) By November 1, 2016, and biennially thereafter, the commissioner ~~of human services~~ shall provide sufficient information to the members of the legislative committees having jurisdiction over mental health funding and policy issues to evaluate the use of funds appropriated under this section. The commissioner shall provide, at a minimum, the following information:

(1) the amount of funding to adult mental health initiatives, what programs and services were funded in the previous two years, gaps in services that each initiative brought to the attention of the commissioner, and outcome data for the programs and services that were funded; and

(2) the amount of funding for other targeted services and the location of services.

(b) This subdivision expires January 1, 2032.

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

Sec. 5. Minnesota Statutes 2024, section 245.4661, is amended by adding a subdivision to read:

Subd. 12. **Oversight of direct payments.** (a) The commissioner shall develop and maintain monitoring, financial review, and accountability procedures for all direct payments issued under this section.

(b) Recipients of direct payments must comply with all documentation, reporting, and expenditure requirements established by the commissioner.

(c) The commissioner may require corrective action, suspend payments, or recover funds if a recipient fails to comply with requirements established under this subdivision.

(d) The commissioner shall develop a direct payment acknowledgment process to ensure that recipients understand the terms, conditions, and oversight requirements associated with direct payments.

(e) The commissioner is authorized to engage in rulemaking to fulfill the requirements of this subdivision.

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

Sec. 6. Minnesota Statutes 2024, section 245I.011, subdivision 5, is amended to read:

Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or government entity certified under the following sections must comply with all of the responsibilities assigned to a license holder under this chapter except subdivision 1:

(1) an assertive community treatment provider under section 256B.0622, subdivision 3a;

(2) an adult rehabilitative mental health services provider under section 256B.0623;

(3) a mobile crisis team under section 256B.0624;

(4) a children's therapeutic services and supports provider under section 256B.0943;

(5) a children's intensive behavioral health services provider under section 256B.0946; ~~and~~

(6) an intensive nonresidential rehabilitative mental health services provider under section 256B.0947~~.~~; and

(7) effective July 1, 2027, or upon federal approval, whichever is later, a coordinated specialty care team under section 256B.0672.

(b) An individual, organization, or government entity certified under the sections listed in paragraph (a), clauses (1) to ~~(6)~~ (7), must obtain a criminal background study for each staff person and volunteer providing direct contact services to a client.

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

Sec. 7. Minnesota Statutes 2024, section 254A.03, subdivision 2, is amended to read:

Subd. 2. **American Indian programs.** There is hereby created a section of American Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human Services, to be headed by a special assistant for American Indian programs on substance misuse and substance use disorder and two assistants to that position. The section shall be staffed with all personnel necessary to fully administer programming for substance misuse and substance use disorder services for American Indians in the state. The special assistant position shall be filled by a person with considerable practical experience in and understanding of substance misuse and substance use disorder in the American Indian community, who shall be responsible to the director of the Alcohol and Drug Abuse Section created in subdivision 1 and shall be in the unclassified service. The special assistant shall meet and consult with the American Indian Advisory Council as described in section 254A.035 and serve as a liaison to the Minnesota Indian Affairs Council and tribes to report on the status of substance misuse and substance use disorder among American Indians in the state of Minnesota. The special assistant with the approval of the director shall:

(1) administer direct payments using funds appropriated for American Indian groups, organizations and reservations within the state for American Indian substance misuse and substance use disorder programs;

(2) establish policies and procedures for such American Indian programs with the assistance of the American Indian Advisory Board; and

(3) hire and supervise staff to assist in the administration of the American Indian program section within the Alcohol and Drug Abuse Section of the Department of Human Services.

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

Sec. 8. Minnesota Statutes 2025 Supplement, section 254B.02, subdivision 5, is amended to read:

Subd. 5. **Tribal allocation.** The commissioner may make direct payments to Tribal Nation servicing agencies from money allocated under this section to support individuals with substance use disorders and determine eligibility for behavioral health fund payments.

The payment must not be less than 133 percent of the Tribal Nations payment for the fiscal year ending June 30, 2009, adjusted in proportion to the statewide change in the appropriation for this chapter.

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

Sec. 9. Minnesota Statutes 2025 Supplement, section 254B.03, subdivision 4, is amended to read:

Subd. 4. **Division of costs.** (a) Except for services provided by a county under section 254B.09, subdivision 1, or services provided under section 256B.69, the county shall, out of local money, pay the state for ~~22.95~~ 50 percent of the cost of substance use disorder services, except for those services provided to persons enrolled in medical assistance under chapter 256B and room and board services under section 254B.0505, subdivision 1. Counties may use the indigent hospitalization levy for treatment and hospital payments made under this section.

(b) ~~22.95~~ 50 percent of any state collections from private or third-party pay, less 15 percent for the cost of payment and collections, must be distributed to the county that paid for a portion of the treatment under this section.

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

Sec. 10. Minnesota Statutes 2025 Supplement, section 254B.0503, subdivision 1, is amended to read:

Subdivision 1. **Eligible vendor requirements.** (a) Vendors of room and board are eligible for behavioral health fund payment if the vendor:

(1) has rules prohibiting residents bringing chemicals into the facility or using chemicals while residing in the facility and provide consequences for infractions of those rules;

(2) is determined to meet applicable health and safety requirements;

(3) is not a jail or prison;

(4) is not concurrently receiving funds under chapter 256I for the recipient;

(5) admits individuals who are 18 years of age or older;

(6) is registered as a board and lodging or lodging establishment according to section 157.17;

(7) has awake staff on site whenever a client is present;

(8) has staff who are at least 18 years of age and meet the requirements of section 245G.11, subdivision 1, paragraph (b);

(9) has emergency behavioral procedures that meet the requirements of section 245G.16;

(10) meets the requirements of section 245G.08, subdivision 5, if administering medications to clients;

(11) meets the abuse prevention requirements of section 245A.65, including a policy on fraternization and the mandatory reporting requirements of section 626.557;

(12) documents coordination with the treatment provider to ensure compliance with section 254B.03, subdivision 2;

(13) protects client funds and ensures freedom from exploitation by meeting the provisions of section 245A.04, subdivision 13;

(14) has a grievance procedure that meets the requirements of section 245G.15, subdivision 2; and

(15) has sleeping and bathroom facilities for men and women separated by a door that is locked, has an alarm, or is supervised by awake staff.

(b) Programs providing children's mental health crisis admissions and stabilization under section 245.4882, subdivision 6, are eligible vendors of room and board.

(c) Programs providing children's residential services under section 245.4882, except services for individuals who have a placement under chapter 260C or 260D, are eligible vendors of room and board.

(d) A vendor that is not licensed as a residential treatment program must have a policy to address staffing coverage when a client may unexpectedly need to be present at the room and board site.

(e) No new vendors for room and board services may be approved after June 30, 2025, to receive payments from the behavioral health fund, under the provisions of section 254B.04, subdivision 2a. Room and board vendors that were approved and operating prior to July 1, 2025, may continue to receive payments from the behavioral health fund for services provided until ~~June 30, 2027~~ December 31, 2026. Room and board vendors providing services in accordance with section 254B.04, subdivision 2a, will no longer be eligible to claim reimbursement for room and board services provided on or after ~~July~~ January 1, 2027.

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

Sec. 11. Minnesota Statutes 2025 Supplement, section 254B.0509, subdivision 2, is amended to read:

Subd. 2. **Annual adjustments.** Effective January 1, 2027, and annually thereafter, the commissioner of human services must adjust the payment rates under subdivision 1 according to the change from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined using the Centers for Medicare and Medicaid Services Medicare Economic Index as forecasted in the fourth quarter of the calendar year before the rate year. Notwithstanding this subdivision, rates must not be adjusted lower than those established on January 1, 2026.

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

Sec. 12. Minnesota Statutes 2024, section 254B.06, subdivision 2, is amended to read:

Subd. 2. **Allocation of collections.** The commissioner shall allocate ~~77.05~~ 50 percent of patient payments and third-party payments to the special revenue account and ~~22.95~~ 50 percent to the county financially responsible for the patient.

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

Sec. 13. **[256B.0618] COVERAGE FOR DETAINED INDIVIDUALS.**

(a) An inmate of a correctional facility who is conditionally released under section 241.26, 244.065, or 631.425 is eligible for medical assistance if the individual:

(1) does not require the security of a public detention facility and is housed:

(i) in a halfway house or community correction center; or

(ii) under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections; and

(2) meets all other eligibility requirements of this chapter.

(b) 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 medical assistance services received:

(1) while an inpatient in a medical institution as defined in Code of Federal Regulations, title 42, section 435.1010;

(2) by an eligible juvenile in accordance with the Consolidated Appropriations Act, 2023, Public Law 117-328, part 5121; and

(3) by an eligible individual under with section 256B.0761.

(c) Security logistics and costs related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

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

Sec. 14. **[256B.0619] CARCERAL TARGETED CASE MANAGEMENT SERVICES.**

Subdivision 1. **Generally.** Effective January 1, 2027, or upon federal approval, whichever is later, medical assistance covers carceral targeted case management services in accordance with section 256B.0761 and United States Code, title 42, sections 1396a(a)(84); 1396d(a)(32); 1397bb(d); and 1397jj(b)(2) and (7).

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

(b) "Comprehensive care plan" means a person-centered plan that includes goals, tasks, and services identified through screening and assessments and agreed upon by all parties. This includes but is not limited to identifying resources and services necessary to meet the individual's physical, behavioral health, and health-related social needs prerelease and postrelease.

(c) "Consultation" means communication from a carceral targeted case manager to other providers working with the same individual to inform, inquire, and instruct regarding the individual's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, including but not limited to the education services, social services, probation, home, primary care, medication prescribers, disabilities services, and other mental health providers and to direct and coordinate clinical service components provided to the justice-involved individual.

(d) "Targeted case management for justice-involved individuals" means the provision of both county targeted case management and public or private vendor service coordination services for the purpose of bridging prerelease and postrelease medical assistance services to support the physical, behavioral health, and health-related social needs of justice-involved individuals.

(e) "Targeted case management services" means services that assist medical assistance eligible persons to gain access to needed medical, social, educational, and other services.

Subd. 3. **Eligibility.** The following individuals are eligible for carceral targeted case management services:

(1) individuals eligible for medical assistance who meet all eligibility requirements under United States Code, title 42, section 1396a(nn);

(2) individuals eligible for medical assistance who meet eligibility requirements for the Children's Health Insurance Program under United States Code, title 42, section 1397jj(b)(7); or

(3) individuals eligible for medical assistance who are currently incarcerated at a section 1115 reentry demonstration pilot facility and meet the participation requirements in section 256B.0761, subdivision 2.

Subd. 4. **Carceral targeted case management services.** (a) For individuals eligible for services under subdivision 3, clause (1) or (2), carceral targeted case management care coordination is available for 30 days before release and up to 180 days postrelease. For individuals eligible for services under subdivision 3, clause (3), carceral targeted case management care coordination is available for up to 90 days before release and up to 180 days postrelease.

(b) Carceral targeted case management care coordination includes:

(1) comprehensive assessment and periodic reassessment addressing physical, behavioral, and health-related social needs in accordance with section 256B.0761 and United States Code, title 42, sections 1396a(nn) and 1397jj(b)(7).

(2) comprehensive care plans including but not limited to;

(i) the desired goals of the individual;

(ii) the individual's preferences for services and supports;

(iii) formal and informal services and supports based on areas of assessment, such as social health, mental health, residence, family, education and vocation, safety, legal, self-determination, financial, and chemical health; and

(iv) housing arrangements postrelease.

(3) regular review and revision of the comprehensive care plan with the individual to ensure needs are adequately met by referrals and supports;

(4) coordination of referrals, which must contain more than just a list of resources, to bridge prerelease to postrelease medical assistance services, including but not limited to referrals to community-based services identified as a need on the comprehensive care plan;

(5) warm handoffs and follow-up post release;

(6) monitoring and evaluation of services identified in the comprehensive care plan to ensure personal outcomes are met and to ensure satisfaction with services and service delivery;

(7) consultation with other professionals, including but not limited to community-based mental health providers; and

(8) completion and maintenance of necessary documentation that supports and verifies the activities in this section.

Subd. 5. **Carceral targeted case management provider standards.** Providers eligible to receive medical assistance reimbursement under this section must enroll as a Minnesota Health Care Programs provider. To qualify as a provider of carceral targeted case management services, a provider must:

(1) have a minimum of a bachelor's degree or a license in a health or human services field, comparable training and two years of experience in human services, or credentials from an American Indian Tribe under section 256B.02, subdivision 7;

(2) demonstrate the capacity and experience to provide targeted case management activities for justice-involved individuals as defined in subdivision 2;

(3) be able to coordinate and connect community resources needed by the recipient;

(4) demonstrate administrative capacity and experience to serve the justice-involved population for which the provider will provide services and ensure quality of services under state and federal requirements;

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

(6) demonstrate capacity to document and maintain individual case records under state and federal requirements;

(7) demonstrate the capacity to coordinate with county administrative functions;

(8) be able to coordinate with health care providers to ensure access to necessary health care services;

(9) have a procedure that (i) notifies the recipient of any conflict of interest if the targeted case management service provider also provides the recipient's services and supports, (ii) provides information on all potential conflicts of interest, (iii) obtains the recipient's informed consent, and (iv) provides the recipient with alternatives; and

(10) demonstrate the capacity to achieve the following performance outcomes: (i) access; (ii) quality; and (iii) consumer satisfaction.

Subd. 6. **Medical assistance payment and rate setting.** (a) Carceral targeted case management rates are equal to rates authorized by the commissioner for relocation targeted case management under section 256B.0621, subdivision 10.

(b) The carceral targeted case management rate only includes eligible services delivered to an eligible recipient by an eligible provider.

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

Sec. 15. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 77. **Carceral targeted case management.** Effective January 1, 2027, or upon federal approval, whichever is later, medical assistance covers carceral targeted case management services under 256B.0619.

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

Sec. 16. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 78. **Coordinated specialty care services.** Effective July 1, 2027, or upon federal approval, whichever is later, medical assistance covers coordinated specialty care services according to section 256B.0672.

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

Sec. 17. **[256B.0672] COORDINATED SPECIALTY CARE FOR THE TREATMENT OF EARLY EPISODE PSYCHOSIS.**

Subdivision 1. **Coverage.** (a) Effective July 1, 2027, or upon federal approval, whichever is later, medical assistance covers medically necessary coordinated specialty care services when the services are provided by an entity certified under and meeting the standards in this section.

(b) The provider entity must report individual client outcomes to the commissioner using instruments and protocols approved by the commissioner.

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

(b) "Coordinated specialty care services" means rehabilitative services that include six core activities: (1) cognitive or behavioral psychotherapy; (2) medication management; (3) family education and support; (4) service coordination; (5) case management; and (6) supported employment and education.

(c) "Coordinated specialty care team" means a group of interdisciplinary mental health staff who work as a team to provide coordinated specialty care.

(d) "Early psychosis" means clinical high-risk stage or early-stage psychotic symptoms or psychotic episodes present in Attenuated Psychosis Syndrome and first-episode psychosis. Psychotic symptoms may include but are not limited to combinations of confused thinking, delusions, hallucinations, changed feelings, and changed behavior.

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

Subd. 3. **Eligibility.** An individual who is experiencing early psychosis with a duration of onset of less than two years and has been on antipsychotic medications for less than a total of 12 months is eligible for coordinated specialty care services.

Subd. 4. **Eligibility exclusion.** An individual is not eligible for coordinated specialty care services under this section if it is determined that the individual's psychotic symptoms are attributable primarily to a:

(1) substance-induced psychotic disorder;

(2) major medical condition;

(3) neurocognitive disorder; or

(4) developmental disorder.

Subd. 5. **Provider certification requirements.** (a) The commissioner must establish a process for the certification of coordinated specialty care teams. The certification process must determine if a team meets the standards for coordinated specialty care services under this section and the standards in section 245I.011, subdivision 5. The provider certification process must include ongoing review of required program fidelity standards under subdivision 13. Recertification may occur at any time and must occur at least every three years.

(b) The coordinated specialty care services provider must have at least one team. Each team must be certified.

(c) To be certified under this section, a coordinated specialty care team must:

(1) demonstrate capacity to recruit, hire, manage, and train required team members;

(2) demonstrate adequate administrative ability to ensure availability of services;

(3) demonstrate flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan as defined in section 245I.10, subdivisions 7 and 8;

(4) keep all necessary records required by law;

(5) be an enrolled medical assistance provider; and

(6) meet all treatment team staff requirements outlined in subdivision 7.

(d) The commissioner must establish a process for decertification of a coordinated specialty care team and must require corrective action, medical assistance repayment, or decertification of a coordinated specialty care team 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. The commissioner may decertify a coordinated specialty care team with cause at any time. The decertification is subject to appeal to the state.

Subd. 6. **Covered coordinated specialty care services.** Coordinated specialty care teams must offer and have the capacity to directly provide:

(1) assertive outreach and engagement strategies to encourage involvement in services;

(2) assessment for underlying and contributing factors to eligibility;

(3) person-centered care, delivered in a home and community, extending beyond typical hours of operation, including evenings and weekends;

(4) crisis assessment, planning, and mobile crisis response services under section 256B.0624;

(5) team leadership from a mental health professional who provides ongoing consultation to the team members, coordinates admission screening, and leads the weekly team meetings to facilitate case review and entry to the program;

(6) employment and education services designed to enable individuals to retain or rehabilitate function in workplace and educational settings consistent with individual preferences;

(7) family psychoeducation and support provided to the client's family and other natural supports to restore and strengthen the client's unique social and family relationships;

(8) individual and group psychotherapy, including but not limited to cognitive behavioral therapies;

(9) care coordination services in clinic, community, and home settings;

(10) pharmacotherapy;

(11) medication management; and

(12) primary care coordination provided by a mental health professional authorized to prescribe psychiatric medications.

Subd. 7. **Team members.** (a) Each coordinated specialty care team must have a program director, psychiatric care provider, supported employment and education specialist, and case manager.

(b) Coordinated specialty care teams may have a certified peer specialist, a certified peer recovery specialist, and a certified family peer specialist.

Subd. 8. **Program director.** The program director must be a mental health professional or a clinical trainee qualified according to section 245I.04, subdivision 6, and a single full-time staff member. The program director must be dedicated to the coordinated specialty care team, responsible for overseeing the administrative operations of the team, and responsible for supervising team members to ensure delivery of best and ethical practices. The program director is responsible for:

(1) serving as the primary liaison for referrals to the program;

(2) performing assessment and intake interviews for potential coordinated specialty care services clients;

(3) ensuring medical necessity has been established to support all services delivered;

(4) engaging clients and family members in treatment and during treatment;

(5) actively participating in the coordinated specialty care team and providing direct services to clients; and

(6) ensuring that overall treatment supervision for the coordinated specialty care team is available after regular business hours and on weekends and holidays and that services are provided by a qualified member of the team.

Subd. 9. **Psychiatric care provider.** (a) The psychiatric care provider must:

(1) be a mental health professional qualified according to section 245I.04, subdivision 2, clause (1) or (4), who is authorized to prescribe psychiatric medications as part of the mental health professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals and families, including but not limited to the population served and specifically persons experiencing psychosis.

(2) fulfill the following functions for coordinated specialty care clients:

(i) provide assessment and treatment of clients' symptoms and response to medications, including but not limited to side effects;

(ii) provide brief therapy to clients;

(iii) provide diagnostic and medication education to clients, with medication decisions based on shared decision making;

(iv) monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and

(v) conduct home and community visits;

(3) be employed at no less than 0.20 full-time equivalent and comply with the staffing requirements in paragraph (b); and

(4) provide psychiatric backup to the program after regular business hours and on weekends and holidays. The psychiatric care provider may delegate this duty to another qualified psychiatric provider.

(b) Psychiatric care providers must have designated hours to work on the coordinated specialty care team with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share the psychiatric care provider role on any one team. Backup coverage must be arranged when the psychiatric care provider is on vacation or is unavailable for any reason. If an individual is receiving care from a medication prescriber who is an ad hoc member of the team or a primary care provider, the psychiatric care provider is responsible for providing continuity of care with other medical providers, including but not limited to the ad hoc psychiatrist, primary care provider, or advanced practice registered nurse, in the team meetings and treatment planning.

Subd. 10. **Individual and group psychotherapy provider.** An individual or group psychotherapy provider must:

(1) be a mental health professional qualified under section 245I.04, subdivision 2; a clinical trainee qualified under section 245I.04, subdivision 6; or a mental health practitioner qualified under section 245I.04, subdivision 4, who has prior experience with providing mental health services to individuals and families, particularly persons experiencing psychosis; and

(2) be responsible for:

(i) providing individual and group therapy or skills training; and

(ii) working with clients to identify goals, learn about symptoms and symptom management through social and coping skills training, receive psychoeducation, learn relaxation techniques, and engage in behavioral activation and other therapeutic techniques in both an individual and group setting.

Subd. 11. **Case manager.** A case manager must be a case management service provider as defined in section 245.462, subdivision 4, or 245.4871, subdivision 4, and be responsible for providing case management and family community support services as established in section 245.4711 or 245.4881.

Subd. 12. **Mental health certified peer specialist and certified family peer specialist.** (a) A coordinated specialty care team may have:

(1) a mental health certified peer specialist qualified under section 245I.04, subdivision 10;

(2) a mental health certified family peer specialist qualified under section 245I.04, subdivision 12; or

(3) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8.

Subd. 13. **Compliance with evidence-based practice and data reporting.** (a) A coordinated specialty care team must remain in compliance with fidelity standards as measured by a fidelity tool for the treatment of early episode psychosis approved by the commissioner. A team must submit data necessary to ensure fidelity with evidence-based practice models in a form and manner prescribed by the commissioner.

(b) A team must submit quality and outcomes data, including but not limited to client satisfaction data, to the commissioner on a timeline and in a form and manner prescribed by the commissioner.

Subd. 14. **Coordinated specialty care team variances.** The commissioner may grant a variance to specific requirements under this section for a coordinated specialty care team

when the coordinated specialty care team demonstrates an inability to meet the specific requirement and how the team will ensure that the variance does not negatively impact outcomes for clients. The commissioner may require a plan of action for the coordinated specialty care team to come into compliance with the specific variance requirement and establish specific time limits for the variance. A decision to grant or deny a variance request is final and not subject to appeal.

Subd. 15. **Concurrent services.** (a) The rate for coordinated specialty care services does not include medical assistance payment for the following services:

(1) inpatient psychiatric hospital treatment;

(2) partial hospitalization;

(3) child or adult mental health day treatment services;

(4) physician services outside of care provided by a psychiatrist serving as a member of the treatment team;

(5) medical assistance room and board rate as defined in section 256B.056, subdivision 5d;

(6) home and community-based waiver services;

(7) mental health services identified in a child's individualized education program;

(8) child and family psychoeducation services as defined in section 256B.0671, subdivision 5;

(9) dialectical behavior therapy as defined in section 256B.0671, subdivision 6;

(10) neuropsychological assessments as defined in section 256B.0671, subdivision 8;

(11) neuropsychological testing as defined in section 256B.0671, subdivision 9; and

(12) psychological testing as defined in section 256B.0671, subdivision 10.

(b) The services in paragraph (a) may be billed separately.

Subd. 16. **Excluded services.** The following services are not covered under this section and are not eligible for medical assistance payment while an individual is receiving coordinated specialty care services:

(1) mental health residential treatment, except during the last 30 days of residential treatment to support discharge planning;

(2) children's therapeutic services and supports as defined in section 256B.0943, except for children's day treatment;

(3) intensive rehabilitative mental health services as defined in section 256B.0947;

(4) assertive community treatment services as defined in section 256B.0622;

(5) mental health targeted case management under section 245.4881; and

(6) mental health clinical care consultation as defined in section 256B.0671, subdivision 7.

Subd. 17. **Payments.** The commissioner must make payments to each designated provider for the provision of coordinated specialty care services under subdivision 6 to each eligible individual under subdivision 3.

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

Sec. 18. Minnesota Statutes 2024, section 256B.0761, subdivision 2, is amended to read:

Subd. 2. **Eligible individuals.** ~~Notwithstanding section 256B.055, subdivision 14,~~ Individuals are eligible to receive services under this demonstration if they are eligible under section 256B.055, subdivision 3a, 6, 7, 7a, 9, 15, 16, or 17, as determined by the commissioner in collaboration with correctional facilities, local governments, and Tribal governments.

Sec. 19. Minnesota Statutes 2024, section 297E.02, subdivision 3, is amended to read:

Subd. 3. **Collection; disposition.** (a) Taxes imposed by this section are due and payable to the commissioner when the gambling tax return is required to be filed. Distributors must file their monthly sales figures with the commissioner on a form prescribed by the commissioner. Returns covering the taxes imposed under this section must be filed with the commissioner on or before the 20th day of the month following the close of the previous calendar month. The commissioner shall prescribe the content, format, and manner of returns or other documents pursuant to section 270C.30. The proceeds, along with the revenue received from all license fees and other fees under sections 349.11 to 349.191, 349.211, and 349.213, must be paid to the commissioner of management and budget for deposit in the general fund.

(b) The sales tax imposed by chapter 297A on the sale of pull-tabs and tipboards by the distributor is imposed on the retail sales price. The retail sale of pull-tabs or tipboards by

the organization is exempt from taxes imposed by chapter 297A and is exempt from all local taxes and license fees except a fee authorized under section 349.16, subdivision 8.

(c) One-half of one percent of the revenue deposited in the general fund under paragraph (a), is appropriated to the commissioner of human services for the compulsive gambling treatment program established under section 245.98. One-half of one percent of the revenue deposited in the general fund under paragraph (a), is appropriated to the commissioner of human services for a grant to the state affiliate recognized by the National Council on Problem Gambling to increase public awareness of problem gambling, education and training for individuals and organizations providing effective treatment services to problem gamblers and their families, and research relating to problem gambling. Money appropriated by this paragraph must supplement and must not replace existing state funding for these programs.

(d) The commissioner of human services must provide to the state affiliate recognized by the National Council on Problem Gambling a monthly statement of the amounts deposited under paragraph (c). Beginning January 1, 2022, the commissioner of human services must provide to the chairs and ranking minority members of the legislative committees with jurisdiction over treatment for problem gambling and to the state affiliate recognized by the National Council on Problem Gambling an annual reconciliation of the amounts deposited under paragraph (c). The annual reconciliation under this paragraph must include the amount allocated to the commissioner of human services for the compulsive gambling treatment program established under section 245.98, and the amount allocated to the state affiliate recognized by the National Council on Problem Gambling. The annual reconciliation must also include any rollover amounts from the previous fiscal year and the utilization of those amounts during the current reporting period.

Sec. 20. Laws 2025, First Special Session chapter 9, article 4, section 2, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 21. Laws 2025, First Special Session chapter 9, article 4, section 23, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 22. Laws 2025, First Special Session chapter 9, article 4, section 38, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 23. Laws 2025, First Special Session chapter 9, article 4, section 39, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 24. Laws 2025, First Special Session chapter 9, article 4, section 40, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 25. Laws 2025, First Special Session chapter 9, article 4, section 41, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 26. Laws 2025, First Special Session chapter 9, article 4, section 42, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 27. Laws 2025, First Special Session chapter 9, article 4, section 43, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 28. Laws 2025, First Special Session chapter 9, article 4, section 44, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 29. Laws 2025, First Special Session chapter 9, article 4, section 50, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

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

Sec. 30. Laws 2025, First Special Session chapter 9, article 4, section 51, is amended to read:

Sec. 51. **RECOVERY RESIDENCE WORK GROUP.**

(a) The commissioner of human services must convene a work group to develop recommendations specific to recovery residences. The work group must:

(1) produce a report that examines how other states fund recovery residences, identifying best practices and models that could be applicable to Minnesota;

(2) engage with stakeholders to ensure meaningful collaboration with key external stakeholders on the ideas being developed that will inform the final plan and recommendations; and

(3) create an implementable plan addressing housing needs for individuals in outpatient substance use disorder treatment that includes:

(i) clear strategies for aligning housing models with individual treatment needs;

(ii) an assessment of funding streams, including potential federal funding sources;

(iii) a timeline for implementation with key milestones and action steps;

(iv) recommendations for future resource allocation to ensure long-term housing stability for individuals in recovery;

(v) specific recommendations for policy or legislative changes that may be required to support sustainable recovery housing solutions, including challenges faced by recovery residences resulting from state and local housing regulations and ordinances; and

(vi) recommendations for potentially delegating the commissioner's recovery residence certification duties under Minnesota Statutes, sections 254B.21 to 254B.216 to a third-party organization.

(b) The work group must include but is not limited to:

(1) at least two designees from the Department of Human Services representing: (i) behavioral health; and (ii) homelessness and housing and support services;

(2) the commissioner of health or a designee;

(3) two people who have experience living in a recovery residence;

(4) representatives from at least three substance use disorder lodging facilities currently operating in Minnesota;

(5) three representatives from county social services agencies, at least one from inside the seven-county metropolitan area and one from outside the seven-county metropolitan area;

(6) a representative from a Tribal social services agency;

(7) representatives from the state affiliate of the National Alliance for Recovery Residences; and

(8) representatives from state mental health advocacy and adult mental health provider organizations.

(c) The work group must meet at least monthly and as necessary to fulfill its responsibilities. The commissioner of human services must provide administrative support and meeting space for the work group. The work group may conduct meetings remotely.

(d) The commissioner of human services must make appointments to the work group by October 1, 2025, and convene the first meeting of the work group by January 15, 2026.

(e) The work group must submit a final report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on or before ~~January~~ July 1, ~~2027~~ 2026.

Sec. 31. **DIRECTION TO COMMISSIONER; CARCERAL TARGETED CASE MANAGEMENT SERVICES BILLING UNITS.**

The commissioner of human services must establish a new billing code for carceral targeted case management services. The commissioner must identify reimbursement rates for the newly defined codes, as required under Minnesota Statutes, section 256B.0619, subdivision 6. The new billing codes must correspond to a 15-minute unit. The new billing codes must be available for 180 days postrelease.

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

Sec. 32. **REPEALER.**

Minnesota Statutes 2024, section 256B.055, subdivision 14, is repealed.

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

ARTICLE 3
HOUSING

Section 1. Minnesota Statutes 2025 Supplement, section 245C.03, subdivision 6, is amended to read:

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

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

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

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

Sec. 2. Minnesota Statutes 2025 Supplement, section 245C.10, subdivision 6, is amended to read:

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

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

Sec. 3. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended to read:

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

(b) The commissioner shall revalidate:

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

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

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

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

(c) The commissioner shall conduct revalidation as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) serves primarily a pediatric population.

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

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2024, section 256B.0658, is amended to read:

256B.0658 HOUSING ACCESS GRANTS.

(a) The commissioner of human services shall award through a competitive process contracts for grants to public and private agencies to support and assist individuals with a disability ~~as defined in section 256B.051, subdivision 2, paragraph (e),~~ to access housing. For the purposes of this section, "individual with a disability" means an individual who:

(1) is aged, blind, or disabled as determined by the criteria used by the title II program of the Social Security Act, United States Code, title 42, section 416; or

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

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

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

Sec. 5. Minnesota Statutes 2024, section 256L.03, subdivision 1, is amended to read:

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

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

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

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

Sec. 6. **HOUSING STABILIZATION SERVICES REDESIGN.**

Subdivision 1. **Direction to commissioner.** The commissioner of human services must develop recommendations for designing and implementing a program to support individuals experiencing or at risk of homelessness to obtain and maintain safe, stable housing.

Subd. 2. **Recommendations.** Recommendations developed by the commissioner must:

(1) prioritize establishing a housing services benefit specifically for Minnesota Tribal governments and urban Indian organizations;

(2) utilize evidence-based and promising practices to prevent and reduce homelessness;

(3) identify a gap in available housing services and supports and not duplicate an existing program;

(4) identify expected outcomes and measures that could be used to track effectiveness;

(5) incorporate tools and system changes necessary to protect program integrity and prevent fraud, waste, and abuse; and

(6) include proposed statutory changes and state appropriations that would be necessary to implement the program.

Subd. 3. **Community engagement.** In developing recommendations, the commissioner must consult with the legislature, other state agencies, Tribal Nations, and community partners, including counties, providers, health plans, and people experiencing or at risk of homelessness.

Subd. 4. **Legislative report.** By September 15, 2027, the commissioner must present final recommendations and draft legislation to establish a housing services benefit specifically for Tribal governments and urban Indian organizations and a statewide housing services benefit to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 7. **REPEALER.**

(a) Minnesota Statutes 2024, section 256B.051, subdivisions 1, 4, and 7, is repealed.

(b) Minnesota Statutes 2025 Supplement, section 256B.051, subdivisions 2, 3, 5, 6, 6a, 6b, 8, 9, and 10, is repealed.

(c) Laws 2025, First Special Session chapter 3, article 18, section 3, is repealed.

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

ARTICLE 4
DEPARTMENT OF HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Section 1. **[245A.034] LICENSEE CONDUCT TOWARD PUBLIC OFFICIALS.**

(a) Applicants, license holders, certification holders, and controlling individuals must refrain from engaging in conduct that threatens the safety or well-being of Department of Human Services staff, county employees, or other individuals acting under the authority of the commissioner for duties authorized under this chapter, chapter 260E, and section 626.557. Prohibited conduct includes but is not limited to:

(1) assault, including attempts, under sections 609.221, 609.222, 609.223, 609.2231, and 609.224, regardless of whether there is a criminal proceeding or conviction;

(2) threats of violence under section 609.713, regardless of whether there is a criminal proceeding or conviction;

(3) harassment or stalking under section 609.749, regardless of whether there is a criminal proceeding or conviction;

(4) damage to property under section 609.595, regardless of whether there is a criminal proceeding or conviction; or

(5) any other act with the intent to cause harm to personal safety.

(b) If the commissioner determines that conduct prohibited by paragraph (a) occurred to an individual engaged in licensing, certification, investigation, or compliance activities, the commissioner may take action under sections 245A.05, 245A.06, or 245A.07.

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

Sec. 2. Minnesota Statutes 2025 Supplement, section 245A.07, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. If the order is issued through the provider hub, the appeal must be received by the commissioner within ten calendar days from the date the commissioner issued the order through the hub. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (i) and (j), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing

under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The appeal of an order to pay a fine must be made in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the fine has been ordered. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. If the order is issued through the provider hub, the appeal must be received by the commissioner within ten calendar days from the date the commissioner issued the order through the hub.

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

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

(4) Fines shall be assessed as follows:

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

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

(iii) the license holder shall forfeit ~~$200~~ $500 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the

provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(iv) the license holder shall forfeit ~~$100~~ $300 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, or $200 fine in items (i) to (iii).

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

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

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

Sec. 3. Minnesota Statutes 2025 Supplement, section 256.01, subdivision 2, is amended to read:

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

(a) Administer and supervise the forms of public assistance provided for by state law and other welfare activities or services that are vested in the commissioner. Administration and supervision of human services activities or services includes, but is not limited to, assuring timely and accurate distribution of benefits, completeness of service, and quality

program management. In addition to administering and supervising human services activities vested by law in the department, the commissioner shall have the authority to:

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

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

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

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

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

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

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

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

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

(c) Administer and supervise all noninstitutional service to persons with disabilities, including persons who have vision impairments, and persons who are deaf, deafblind, and hard-of-hearing or with other disabilities. The commissioner may provide and contract for

the care and treatment of qualified indigent children in facilities other than those located and available at state hospitals operated by the executive board when it is not feasible to provide the service in state hospitals operated by the executive board.

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

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

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

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

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

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

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

(k) Have the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public welfare. To carry out such experimental projects, it is further provided that the commissioner of human services is authorized to waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver shall provide alternative methods and procedures of administration,

shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and in no event shall the duration of a project exceed four years. It is further provided that no order establishing an experimental project as authorized by the provisions of this section shall become effective until the following conditions have been met:

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

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

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

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

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

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

(n) Develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph shall be deposited in the state treasury and credited to a special account until the balance in the account reaches $1,000,000. When the balance in the account exceeds $1,000,000, the excess shall be transferred and credited

to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

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

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

(2) the county board shall submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format shall be accepted by the commissioner;

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

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

(5) the final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the report for that

reporting period and the county board must repay any funds associated with the report received for that reporting period;

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

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

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

(q) Be responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the human services programs administered by the department, including but not limited to a preenrollment risk assessment. A preenrollment risk assessment under this paragraph must be conducted in accordance with the procedures and criteria established in section 256B.04, subdivision 21a.

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

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

(t) Have the authority to administer a supplemental drug rebate program for drugs purchased under the medical assistance program. The commissioner may enter into supplemental rebate contracts with pharmaceutical manufacturers and may require prior authorization for drugs that are from manufacturers that have not signed a supplemental

rebate contract. Prior authorization of drugs shall be subject to the provisions of section 256B.0625, subdivision 13.

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

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

(w) Designate community information and referral call centers and incorporate cost reimbursement claims from the designated community information and referral call centers into the federal cost reimbursement claiming processes of the department according to federal law, rule, and regulations. Existing information and referral centers provided by Greater Twin Cities United Way or existing call centers for which Greater Twin Cities United Way has legal authority to represent, shall be included in these designations upon review by the commissioner and assurance that these services are accredited and in compliance with national standards. Any reimbursement is appropriated to the commissioner and all designated information and referral centers shall receive payments according to normal department schedules established by the commissioner upon final approval of

allocation methodologies from the United States Department of Health and Human Services Division of Cost Allocation or other appropriate authorities.

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

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

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

Sec. 4. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended to read:

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

(b) The commissioner shall revalidate:

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

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

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

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

(c) The commissioner shall conduct revalidation as follows:

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

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

~~(3)~~ (2) if a provider fails to respond or remedy a deficiency within the 30-day time period, give 60-day notice of termination and immediately suspend the provider's ability to bill. The provider does not have the right to appeal suspension of ability to bill.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) serves primarily a pediatric population.

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

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

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

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and

fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064.

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

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

Sec. 5. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision to read:

Subd. 21a. **Preenrollment assessment.** (a) Before enrolling a provider or agency, the commissioner may complete a preenrollment risk assessment of the provider or agency seeking to enroll to confirm the provider or agency's eligibility and the provider or agency's ability to meet the requirements of this chapter. The commissioner must utilize a risk-score framework as a component of the assessment that identifies service-specific fraud risk indicators, including but not limited to organizational readiness, financial stability, compliance history, and addressing service necessity.

(b) Based on the assessment of fraud risk indicators described in paragraph (a), the commissioner may deem the applicant ineligible and deny or rescind enrollment. The decision to deny or rescind enrollment must be made in writing and sent using a signature-verified confirmed delivery method. An applicant may request reconsideration of the decision regarding the applicant's eligibility in writing within 30 business days after

the date the notice was issued. The commissioner must notify each applicant of the commissioner's final decision regarding the applicant's eligibility.

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

Sec. 6. **[256B.0647] REMITTANCE ADVICE MONETARY RECOVERY.**

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

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

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

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

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

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

(5) other information required by the commissioner.

ARTICLE 5
UNIFORM SERVICE STANDARDS

Section 1. Minnesota Statutes 2024, section 245.735, subdivision 6, is amended to read:

Subd. 6. **Section 223 of the Protecting Access to Medicare Act entities.** ~~(a) The commissioner must request federal approval to participate in the demonstration program established by section 223 of the Protecting Access to Medicare Act and, if approved, to continue to participate in the demonstration program as long as federal funding for the demonstration program remains available from the United States Department of Health and Human Services. To the extent practicable, the commissioner shall align the requirements of the demonstration program with the requirements under this section for CCBHCs receiving medical assistance reimbursement under the authority of the state's Medicaid state plan. A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.~~

~~(b) The commissioner must follow federal payment guidance, including payment of the CCBHC daily bundled rate for services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. Services provided by a CCBHC operating under the authority of the state's Medicaid state plan will not receive the prospective payment system rate for services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service.~~

~~(c)~~ Payment for services rendered by CCBHCs to individuals who have commercial insurance as the primary payer and medical assistance as secondary payer is subject to the requirements under section 256B.37. Services provided by a CCBHC operating under the authority of the 223 demonstration or the state's Medicaid state plan will not receive the prospective payment system rate for services rendered by CCBHCs to individuals who have commercial insurance as the primary payer and medical assistance as the secondary payer.

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

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

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

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

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

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

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

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

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

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

(9) programs licensed by the commissioner of corrections;

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

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

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

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

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

(15) mental health outpatient services for adults with mental illness or children with mental illness, except for programs under section 245A.044;

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

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

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 3. **[245A.044] LICENSED NONRESIDENTIAL BEHAVIORAL HEALTH SERVICES.**

Subdivision 1. **License required for certain nonresidential behavioral health services.** (a) Beginning January 1, 2028, behavioral health service providers providing

mental health and substance use disorder services must obtain a license under this chapter to provide:

(1) adult rehabilitative mental health services under section 245I.22;

(2) children's therapeutic services and supports in the community under section 245I.30 and children's day treatment under section 245I.31;

(3) crisis response services under section 245I.24; and

(4) certified community behavioral health clinic services under section 245I.17.

(b) As a condition of licensure, an applicant or license holder must demonstrate and maintain verification of compliance with:

(1) licensing requirements under this chapter and chapter 245I; and

(2) applicable health care program requirements under Minnesota Rules, parts 9505.0170 to 9505.0475 and 9505.2160 to 9505.2245.

Subd. 2. **Implementation.** (a) Beginning July 1, 2027, the commissioner shall begin issuing licenses to behavioral health service providers listed in subdivision 1. The commissioner shall transition certified providers listed in subdivision 1 into licensure with a phased-in schedule determined by the commissioner. The commissioner shall communicate the schedule of implementation to providers certified under section 245I.011 at least three months before the application is made available.

(b) Applicants for licensure must have an approved certification under section 245I.011 at least 90 days before the date of application.

(c) A provider's certification under section 245I.011, subdivision 5, paragraph (a), clauses (2) to (4), or 6, paragraph (b), expires when the commissioner issues a decision on the provider's license application.

(d) Upon licensure, a license holder must notify clients and staff of policies and procedures outlined in the application.

(e) Notwithstanding paragraphs (a) and (c), subdivision 1, and sections 245I.17, 245I.22, 245I.24, 245I.30, and 245I.31, a provider listed under subdivision 1, paragraph (a), clauses (1) to (4), and certified under section 245I.011 may continue operating past January 1, 2028, until the commissioner issues a licensing decision if the provider submitted an application before January 1, 2028.

(f) The commissioner must disenroll a provider from reimbursement for nonresidential behavioral health services under the following sections if the provider fails to submit an application for licensure within the time frame in paragraph (b):

(1) adult rehabilitative mental health services under section 256B.0623;

(2) crisis response services under section 256B.0624;

(3) children's therapeutic services and supports under section 256B.0943; and

(4) certified community behavioral health clinics under section 256B.0625, subdivision 5m.

(g) The commissioner must disenroll a provider listed in paragraph (f) from medical assistance if:

(1) the application has been denied or the license has been suspended or revoked; and

(2) the provider appealed the application denial or the license suspension or revocation, and the commissioner issued a final order on the appeal affirming the action.

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

Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3, is amended to read:

Subd. 3. **Application fee for initial license or certification.** (a) Except as provided in paragraphs (c) ~~and~~, (d), and (f), for fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a $2,100 application fee with each new application required under this subdivision. The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in paragraph (c), an applicant shall apply for a license to provide services at a specific location.

(c) For a license to provide home and community-based services to persons with disabilities or age 65 and older under chapter 245D, an applicant shall submit an application to provide services statewide. For fees required under subdivision 1, an applicant for an initial license issued by the commissioner to provide home and community-based services under chapter 245D shall submit a $4,200 application fee with each new application.

(d) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner for children's residential facility ~~or mental health clinic licensure or certification~~ shall submit a $500 application fee with each new application required under this subdivision.

(e) For fees required under subdivision 1, an applicant for an initial certification issued by the commissioner for mental health clinic certification shall submit a $2,100 application fee with each new application required under this subdivision.

(f) For fees required under subdivision 1, an applicant for an initial license issued by the commissioner to provide services at a certified community behavioral health clinic under section 245I.17 shall submit a $4,200 application fee with each new application.

Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended to read:

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

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

greater than $400,000 but less than or equal to $450,000	$2,250
greater than $450,000 but less than or equal to $500,000	$2,500
greater than $500,000 but less than or equal to $600,000	$2,850
greater than $600,000 but less than or equal to $700,000	$3,200
greater than $700,000 but less than or equal to $800,000	$3,600
greater than $800,000 but less than or equal to $900,000	$3,900
greater than $900,000 but less than or equal to $1,000,000	$4,250
greater than $1,000,000 but less than or equal to $1,250,000	$4,550
greater than $1,250,000 but less than or equal to $1,500,000	$4,900
greater than $1,500,000 but less than or equal to $1,750,000	$5,200
greater than $1,750,000 but less than or equal to $2,000,000	$5,500
greater than $2,000,000 but less than or equal to $2,500,000	$5,900
greater than $2,500,000 but less than or equal to $3,000,000	$6,200
greater than $3,000,000 but less than or equal to $3,500,000	$6,500
greater than $3,500,000 but less than or equal to $4,000,000	$7,200
greater than $4,000,000 but less than or equal to $4,500,000	$7,800
greater than $4,500,000 but less than or equal to $5,000,000	$9,000
greater than $5,000,000 but less than or equal to $7,500,000	$10,000
greater than $7,500,000 but less than or equal to $10,000,000	$14,000
greater than $10,000,000 but less than or equal to $12,500,000	$18,000
greater than $12,500,000 but less than or equal to $15,000,000	$25,000
greater than $15,000,000 but less than or equal to $17,500,000	$28,000
greater than $17,500,000 but less than $20,000,000	$32,000

greater than $20,000,000 but less than $25,000,000	$36,000
greater than $25,000,000 but less than $30,000,000	$45,000
greater than $30,000,000 but less than $35,000,000	$55,000
greater than $35,000,000	$75,000

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

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

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

(b) A substance use disorder treatment program licensed under chapter 245G, to provide substance use disorder treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 to 74 persons	$5,000
75 to 99 persons	$10,000
100 to 199 persons	$15,000
200 or more persons	$20,000

(c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 or more persons	$5,000

A detoxification program that also operates a withdrawal management program at the same location shall only pay one fee based upon the licensed capacity of the program with the higher overall capacity.

(d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 or more persons	$20,000

(f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(g) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 to 74 persons	$5,000
75 to 99 persons	$10,000
100 to 199 persons	$15,000
200 or more persons	$20,000

(h) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(i) A mental health clinic certified under section 245I.20 shall pay an annual nonrefundable certification fee of ~~$1,550~~ $3,000. If the mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

~~(j) If a program subject to annual fees under paragraph (b) provides services at a primary location with satellite facilities, the satellite facilities must be licensed with the primary location and must be subject to an additional $500 annual nonrefundable license fee per satellite facility.~~

(j) A program licensed to provide behavioral health treatment services licensed under section 245I.22, 245I.24, 245I.30, or 245I.31 shall pay an annual nonrefundable license fee of $3,000 for each license.

(k) Certified community behavioral health clinics licensed under section 245I.17 shall pay an annual nonrefundable license fee of $7,800.

Sec. 6. Minnesota Statutes 2024, section 245A.10, is amended by adding a subdivision to read:

Subd. 4a. **Fees for satellite locations.** (a) If a program subject to annual fees under subdivision 4, paragraph (b), provides services at a primary location with satellite facilities, the satellite facilities are licensed with the primary location and are subject to an additional $500 annual nonrefundable license fee per satellite facility.

(b) If a program subject to annual fees under subdivision 4, paragraph (j), provides services at a primary location with satellite sites or facilities, the satellite locations must be licensed with the primary location and shall pay an additional annual nonrefundable fee according to the following schedule:

(1) one to five satellite locations: $1,500;

(2) six to 19 satellite locations: $3,500; or

(3) 20 or more satellite locations: $5,000.

Sec. 7. Minnesota Statutes 2024, section 245A.65, subdivision 1a, is amended to read:

Subd. 1a. **Determination of vulnerable adult status.** (a) A license holder that provides services to adults who are excluded from the definition of vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (2), must determine whether the person is a vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (4). This determination must be made within 24 hours of:

(1) admission to the licensed program; and

(2) any incident that:

(i) was reported under section 626.557; or

(ii) would have been required to be reported under section 626.557, if one or more of the adults involved in the incident had been vulnerable adults.

(b) Upon determining that a person receiving services is a vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (4), all requirements relative to vulnerable adults under this chapter and section 626.557 must be met by the license holder.

(c) Notwithstanding paragraph (a), clause (1), a license holder providing mobile crisis services must make a determination within 24 hours of first receiving crisis stabilization services under section 245I.24, subdivision 9.

Sec. 8. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Programs licensed by the commissioner.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees of the applicant or license holder who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15; and

(7) all controlling individuals as defined in section 245A.02, subdivision 5a;

(8) notwithstanding clause (3), for children's residential facilities and foster residence settings, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

(b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

(c) This subdivision applies to the following programs that must be licensed under chapter 245A:

(1) adult foster care;

(2) children's residential facilities;

(3) licensed home and community-based services under chapter 245D;

(4) residential mental health programs for adults;

(5) substance use disorder treatment programs under chapter 245G;

(6) withdrawal management programs under chapter 245F;

(7) adult day care centers;

(8) family adult day services;

(9) detoxification programs;

(10) community residential settings;

(11) intensive residential treatment services and residential crisis stabilization under chapter 245I; ~~and~~

(12) treatment programs for persons with sexual psychopathic personality or sexually dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts 9515.3000 to 9515.3110~~.~~;

(13) adult rehabilitative mental health services under chapter 245I;

(14) certified community behavioral health clinic services under chapter 245I;

(15) children's therapeutic services and supports under chapter 245I; and

(16) crisis response services under chapter 245I.

Sec. 9. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended to read:

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

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

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

(i) the individual is not disqualified; or

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

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

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

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

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

(1) being issued a license;

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

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

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

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

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

(7) for background studies affiliated with a personal care provider organization, except as provided in section 245C.03, subdivision 3b, early intensive developmental and behavioral intervention provider, or adult rehabilitative mental health services provider, before ~~a personal care assistant~~ an individual provides services, the ~~personal care assistance provider agency~~ entity must initiate a background study of the ~~personal care assistant~~ individual under this chapter and the ~~personal care assistance provider agency~~ entity must have received a notice from the commissioner that the ~~personal care assistant~~ individual is:

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

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22; or

(8) for background studies affiliated with an early intensive developmental and behavioral intervention provider, before an individual provides services, the early intensive developmental and behavioral intervention provider must initiate a background study for the individual under this chapter and the early intensive developmental and behavioral intervention provider must have received a notice from the commissioner that the individual is:

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

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

Sec. 10. Minnesota Statutes 2025 Supplement, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside;

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program and from working in a children's residential facility or foster residence setting; and

(9) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 2, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense during the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with or access to persons receiving services from the center and from working in a licensed child care center or certified license-exempt child care center.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

(d) This section does not apply to a background study related to an initial application for a child foster family setting license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section ~~256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1, or to a background study for an individual providing early intensive developmental and behavioral intervention services under section 256B.0949~~ 245C.13, subdivision 2, paragraph (c), clause (7).

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

Sec. 11. Minnesota Statutes 2024, section 245G.03, subdivision 1, is amended to read:

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in section 626.557; chapters 245A, 245C, and 260E; and Minnesota Rules, chapter 9544.

(b) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

(c) If a program is licensed according to this chapter and is part of a certified community behavioral health clinic under section ~~245.735~~ 245I.17, the license holder must comply with the requirements in section ~~245.735~~ 245I.17, subdivisions ~~4b to 4e~~ 12 and 13, as part of the licensing requirements under this chapter.

Sec. 12. Minnesota Statutes 2024, section 245I.011, subdivision 3, is amended to read:

Subd. 3. **Certification required.** (a) An individual, organization, or government entity that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause ~~(12)~~ (15), and chooses to be identified as a certified mental health clinic must:

(1) be a mental health clinic that is certified under section 245I.20;

(2) comply with all of the responsibilities assigned to a license holder by this chapter except subdivision 1; and

(3) comply with all of the responsibilities assigned to a certification holder by chapter 245A.

(b) An individual, organization, or government entity described by this subdivision must obtain a criminal background study for each staff person or volunteer who provides direct contact services to clients.

~~(c) If a clinic is certified according to this chapter and is part of a certified community behavioral health clinic under section 245.735, the license holder must comply with the requirements in section 245.735, subdivisions 4b to 4e, as part of the licensing requirements under this chapter.~~

EFFECTIVE DATE. This section is effective the day following final enactment, except the amendment striking paragraph (c) is effective January 1, 2028.

Sec. 13. Minnesota Statutes 2024, section 245I.011, subdivision 5, is amended to read:

Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or government entity certified under the following sections must comply with all of the responsibilities assigned to a license holder under this chapter except subdivision 1:

(1) an assertive community treatment provider under section 256B.0622, subdivision 3a;

~~(2) an adult rehabilitative mental health services provider under section 256B.0623;~~

~~(3) a mobile crisis team under section 256B.0624;~~

~~(4) a children's therapeutic services and supports provider under section 256B.0943;~~

~~(5)~~ (2) a children's intensive behavioral health services provider under section 256B.0946; and

~~(6)~~ (3) an intensive nonresidential rehabilitative mental health services provider under section 256B.0947.

(b) An individual, organization, or government entity certified under the sections listed in paragraph (a)~~, clauses (1) to (6),~~ must obtain a criminal background study for each staff person and volunteer providing direct contact services to a client.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 14. Minnesota Statutes 2024, section 245I.011, is amended by adding a subdivision to read:

Subd. 6. **License required for nonresidential programs.** (a) Beginning January 1, 2028, an individual, organization, or government entity must have a license under this chapter to provide the following services:

(1) adult rehabilitative mental health services, as defined in section 256B.0623;

(2) mobile crisis services, as defined in section 256B.0624; or

(3) children's therapeutic services and supports, as defined in section 256B.0943;

(4) certified community behavioral health clinic services, as defined in sections 245I.17 and 256B.0625, subdivision 5m.

(b) An individual, organization, or government entity certified as any of the following programs shall remain certified according to subdivision 5 until the commissioner issues a license, the commissioner denies the license application, or the certification expires according to chapter 245A:

(1) an adult rehabilitative mental health services provider under section 256B.0623;

(2) a mobile crisis team under section 256B.0624;

(3) a children's therapeutic services and supports provider under section 256B.0943; or

(4) a certified community behavioral health clinic under section 245.735.

Sec. 15. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

Subd. 1a. **Alcohol and drug counselor** "Alcohol and drug counselor" means an individual qualified under section 245G.11, subdivision 5.

Sec. 16. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

Subd. 10a. **Comprehensive evaluation.** "Comprehensive evaluation" means a person-centered, family-centered, and trauma-informed evaluation conducted according to section 245I.17, subdivision 12.

Sec. 17. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

Subd. 18a. **Initial evaluation.** "Initial evaluation" means the assessment and preliminary diagnosis necessary to begin client services and conducted according to section 245I.17.

Sec. 18. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

Subd. 31a. **Psychotherapy.** "Psychotherapy" has the meaning given in section 256B.0671, subdivision 11.

Sec. 19. Minnesota Statutes 2024, section 245I.02, subdivision 33, is amended to read:

Subd. 33. **Rehabilitative mental health services.** "Rehabilitative mental health services" means mental health services provided to ~~an adult~~ a client that enable the client to develop and achieve psychiatric stability, social competencies, personal and emotional adjustment, independent living skills, family roles, and community skills when symptoms of mental illness has impaired any of the client's abilities in these areas. Rehabilitation mental health services include interventions that allow a client to self-monitor, compensate for, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a mental illness. For a child client, rehabilitation includes intervention to restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a mental illness.

Sec. 20. Minnesota Statutes 2024, section 245I.02, subdivision 39, is amended to read:

Subd. 39. **Treatment plan.** "Treatment plan" means services that a license holder formulates to respond to a client's needs and goals. A treatment plan includes individual treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision 8, and 256B.0624, subdivision 11. For a license holder under section 245I.17, treatment plan refers to the integrated treatment plan developed according to section 245I.17, subdivision 13.

Sec. 21. Minnesota Statutes 2024, section 245I.03, subdivision 4, is amended to read:

Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each staff person follows when responding to a client who exhibits behavior that threatens the

immediate safety of the client or others. A license holder's behavioral emergency procedures must incorporate person-centered planning and trauma-informed care.

(b) A license holder's behavioral emergency procedures must include:

(1) a plan designed to prevent the client from inflicting self-harm and harming others;

(2) contact information for emergency resources that a staff person must use when the license holder's behavioral emergency procedures are unsuccessful in controlling a client's behavior;

(3) the types of behavioral emergency procedures that a staff person may use;

(4) the specific circumstances under which the program may use behavioral emergency procedures; ~~and~~

(5) the staff persons whom the license holder authorizes to implement behavioral emergency procedures~~.~~; and

(6) the contact information for the local crisis team.

(c) The license holder's behavioral emergency procedures must not include secluding or restraining a client except as allowed under section 245.8261.

(d) Staff persons must not use behavioral emergency procedures to enforce program rules or for the convenience of staff persons. Behavioral emergency procedures must not be part of any client's treatment plan. A staff person may not use behavioral emergency procedures except in response to a client's current behavior that threatens the immediate safety of the client or others.

Sec. 22. Minnesota Statutes 2024, section 245I.03, is amended by adding a subdivision to read:

Subd. 11. **Quality assurance and improvement plan.** (a) At a minimum, a license holder must develop a written quality assurance and improvement plan that includes plans 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, a license 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.

Sec. 23. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 5, is amended to read:

Subd. 5. **Behavioral health practitioner scope of practice.** (a) A behavioral health practitioner under the treatment supervision of a mental health professional or certified rehabilitation specialist may provide an adult client with client education, rehabilitative mental health services, functional assessments, level of care assessments, crisis planning, and treatment plans. A behavioral health practitioner under the treatment supervision of a mental health professional may provide skill-building services ~~to a child client~~, crisis planning, and complete treatment plans for a child client.

(b) A behavioral health practitioner must not provide treatment supervision to other staff persons. A behavioral health practitioner may provide direction to mental health rehabilitation workers and mental health behavioral aides.

(c) A behavioral health practitioner who provides services to clients according to section 256B.0624 may perform crisis assessments and interventions for a client.

Sec. 24. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, is amended to read:

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

Sec. 25. Minnesota Statutes 2024, section 245I.06, subdivision 1, is amended to read:

Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health professional or certified rehabilitation specialist provides treatment supervision to each staff

person who provides services to a client and who is not a mental health professional or certified rehabilitation specialist. When providing treatment supervision, a treatment supervisor must follow a staff person's written treatment supervision plan.

(b) Treatment supervision must focus on each client's treatment needs and the ability of the staff person under treatment supervision to provide services to each client, including the following topics related to the staff person's current caseload:

(1) a review and evaluation of the interventions that the staff person delivers to each client;

(2) instruction on alternative strategies if a client is not achieving treatment goals;

(3) a review and evaluation of each client's assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) instruction on the cultural norms or values of the clients and communities that the license holder serves and the impact that a client's culture has on providing treatment;

(5) evaluation of and feedback regarding a direct service staff person's areas of competency; ~~and~~

(6) coaching, teaching, and practicing skills with a staff person~~.~~<u>; and</u>

<u>(7) modeling service practices that respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, and coordinate with other involved parties and providers.</u>

(c) A treatment supervisor must provide treatment supervision to a staff person using methods that allow for immediate feedback, including in-person, telephone, and interactive video supervision.

(d) A treatment supervisor's responsibility for a staff person receiving treatment supervision is limited to the services provided by the associated license holder. If a staff person receiving treatment supervision is employed by multiple license holders, each license holder is responsible for providing treatment supervision related to the treatment of the license holder's clients.

Sec. 26. Minnesota Statutes 2024, section 245I.06, subdivision 2, is amended to read:

Subd. 2. **Treatment supervision planning.** (a) A treatment supervisor and the staff person supervised by the treatment supervisor must develop a written treatment supervision plan. The license holder must ensure that a new staff person's treatment supervision plan is completed<u>, approved by the staff person,</u> and implemented by a treatment supervisor and

the new staff person within 30 days of the new staff person's first day of employment. The license holder must review and update each staff person's treatment supervision plan annually.

(b) Each staff person's treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the names and licensures of the treatment supervisors who are supervising the staff person;

(3) how frequently the treatment supervisors must provide treatment supervision to the staff person; and

(4) the staff person's authorized scope of practice, including a description of the client ~~population~~ ages that the staff person serves, and a description of the treatment methods and modalities that the staff person may use to provide services to clients.

Sec. 27. Minnesota Statutes 2024, section 245I.07, is amended to read:

245I.07 PERSONNEL FILES.

(a) For each staff person, a license holder must maintain a personnel file that includes:

(1) verification of the staff person's qualifications required for the position including training, education, practicum or internship agreement, licensure, and any other required qualifications;

(2) documentation related to the staff person's background study;

(3) the hiring date of the staff person;

(4) a description of the staff person's job responsibilities with the license holder;

(5) the date that the staff person's specific duties and responsibilities became effective, including the date that the staff person began having direct contact with clients;

(6) documentation of the staff person's training as required by section 245I.05, subdivision 2;

(7) a verification copy of license renewals that the staff person completed during the staff person's employment;

(8) annual job performance evaluations; and

(9) if applicable, the staff person's alleged and substantiated violations of the license holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license holder's response.

(b) The license holder must ensure that all personnel files are readily accessible for the commissioner's review. The license holder is not required to keep personnel files in a single location.

(c) For a license holder under section 245I.17, a personnel file for staff who provide substance use disorder treatment services must include records of training required under section 245G.13, subdivision 2.

Sec. 28. Minnesota Statutes 2024, section 245I.10, is amended by adding a subdivision to read:

Subd. 2a. **Evaluation, treatment authorization, and planning in a certified community behavioral health clinic.** Notwithstanding subdivisions 2 and 7, a license holder under section 245I.17 must meet the requirements of section 245I.17, subdivisions 11 and 12, for assessments and section 245I.17, subdivision 13, for treatment planning. Service planning and authorization for services delivered by a certified community behavioral health clinic must be done pursuant to the standards in section 245I.17.

Sec. 29. Minnesota Statutes 2024, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety, including withdrawal symptoms, medical conditions, and behavioral and emotional symptoms;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health and substance use disorder treatment;

(10) cultural influences on the client; and

(11) substance use history, if applicable, including:

(i) amounts and types of substances, frequency and duration, route of administration, periods of abstinence, and circumstances of relapse; and

(ii) the impact to functioning when under the influence of substances, including legal interventions.

(c) If the assessor cannot obtain the information that this paragraph requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic

Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is 12 to 17 years of age, an assessor must use either the CRAFFT Questionnaire or the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

~~(3)~~ (4) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client; and

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. ~~The assessor must make referrals for the client as to services required by law.~~

(g) Information from other providers and prior assessments may be used to complete the diagnostic assessment if the source of the information is documented in the diagnostic assessment.

(h) If the client screens positive for a need for substance use disorder services, the assessor must document what actions will be taken to address the client's co-occurring conditions.

(i) The assessor must determine if the client is eligible for targeted case management services according to section 245.462, subdivision 20, or 245.4871, subdivision 6, and refer the client to the county or contracted provider as appropriate.

Sec. 30. Minnesota Statutes 2024, section 245I.10, subdivision 8, is amended to read:

Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's diagnostic assessment or reviewing a client's diagnostic assessment received from a different provider and before providing services to the client beyond those permitted under subdivision 7, the license holder must complete the client's individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's diagnostic assessment and baseline measurements;

(2) for a child client, use a child-centered, family-driven, and culturally appropriate planning process that allows the child's parents and guardians to observe and participate in the child's individual and family treatment services, assessments, and treatment planning;

(3) for an adult client, use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's treatment services, assessments, and treatment planning;

(4) identify the client's treatment goals, measureable treatment objectives, a schedule for accomplishing the client's treatment goals and objectives, a treatment strategy, and the individuals responsible for providing treatment services and supports to the client. The license holder must have a treatment strategy to engage the client in treatment if the client:

(i) has a history of not engaging in treatment; and

(ii) is ordered by a court to participate in treatment services or to take neuroleptic medications;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family, case manager, or other natural supports in the client's treatment planning; and

~~(6) review the client's individual treatment plan every 180 days and update the client's individual treatment plan with the client's treatment progress, new treatment objectives and~~

~~goals or, if the client has not made treatment progress, changes in the license holder's approach to treatment; and~~

~~(7)~~ (6) ensure that the client approves of the client's individual treatment plan unless a court orders the client's treatment plan under chapter 253B.

(b) If the client disagrees with the client's treatment plan, the license holder must document in the client file the reasons why the client does not agree with the treatment plan. If the license holder cannot obtain the client's approval of the treatment plan, a mental health professional must make efforts to obtain approval from a person who is authorized to consent on the client's behalf within 30 days after the client's previous individual treatment plan expired. A license holder may not deny a client service during this time period solely because the license holder could not obtain the client's approval of the client's individual treatment plan. A license holder may continue to bill for the client's otherwise eligible services when the client re-engages in services.

(c) The individual treatment plan must be updated as necessary to reflect the changing needs of the client, including offering assistance in accessing necessary crisis services when the license holder is aware of client need for the services. The license holder must review the client's individual treatment plan every 180 days and update the client's individual treatment plan with the client's treatment progress, new treatment objectives and goals, or, if the client has not made treatment progress, changes in the license holder's approach to treatment.

Sec. 31. **[245I.17] CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC LICENSURE.**

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

(b) "Care coordination" means the activities required to coordinate care across settings and providers for an individual 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.

(c) "CCBHC client" means an individual who has participated in a preliminary screening and risk assessment and who has received at least one of the nine required services from a CCBHC.

(d) "Certified community behavioral health clinic" or "CCBHC" means a provider of integrated behavioral health services that is licensed under this section and compliant with federal CCBHC requirements.

(e) "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.

(f) "Designated collaborating organization" means an entity meeting the requirements of subdivision 5 with a formal agreement with a CCBHC to furnish CCBHC services.

(g) "Federal CCBHC criteria" means the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(h) "Needs assessment" means the community needs assessment described in federal criteria for CCBHC.

(i) "Preliminary screening and risk assessment" means a mandatory screening and risk assessment that is completed at the time of first contact, whether that contact is in person, by telephone, or using other remote communication.

Subd. 2. **Establishment of licensure.** (a) The certified community behavioral health clinic model is an integrated service delivery model that uses evidence-based behavioral health practices to achieve better outcomes for individuals experiencing behavioral health concerns while achieving sustainable rates through cost-based reimbursement for providers and economic efficiencies for payors.

(b) Beginning January 1, 2028, a CCBHC must be licensed under this section and chapter 245A.

(c) A CCBHC must meet the requirements of this section and the federal CCBHC criteria. The commissioner may require a CCBHC applicant or license holder to submit documentation of compliance with state licensing requirements and federal CCBHC criteria. When permitted by the Substance Abuse and Mental Health Services Administration, the commissioner may select a transition date on which revisions to the federal CCBHC criteria become required as licensing conditions for CCBHCs.

Subd. 3. **License extension.** (a) The commissioner shall extend a compliant license holder's license under this section for 36 months.

(b) The commissioner must complete a licensing review that includes an on-site inspection within six months before the expiration of the CCBHC's current license.

(c) Within 180 days of license expiration, a CCBHC license holder must submit to the commissioner all documentation required by the commissioner under subdivision 2, paragraph (b).

Subd. 4. **Required services and scope of licensure.** Within a declared service area, the CCBHC must be able to offer:

(1) mobile crisis services, directly or through a designated collaborating organization under subdivision 4;

(2) outpatient mental health and substance use disorder services under subdivisions 9 and 10;

(3) screening, diagnosis, and risk assessment under subdivision 11;

(4) person- and family-centered treatment planning;

(5) psychiatric rehabilitation services under subdivision 14;

(6) community-based mental health care for veterans under subdivision 15;

(7) outpatient primary care screening and monitoring under subdivision 16;

(8) peer services under subdivision 17; and

(9) targeted case management under subdivision 18.

Subd. 5. **Designated collaborating organization.** (a) If a CCBHC is unable to provide mobile crisis services, the CCBHC may contract with another entity that is licensed to provide mobile crisis services under section 245I.24 and that meets the requirements of the federal CCBHC criteria.

(b) The CCBHC must submit a designated collaborating organization arrangement for approval to the commissioner as part of the licensing process.

Subd. 6. **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 4, 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. 7. **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 licensed 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. 8. **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. 9. **Outpatient mental health services.** (a) A license holder must provide outpatient mental health services that comply with the federal CCBHC criteria and applicable state standards in this chapter, except as provided in this subdivision.

(b) An initial or comprehensive evaluation fulfills the requirements to perform a diagnostic assessment in accordance with section 245I.10, subdivisions 2 and 6.

(c) An integrated treatment plan under this section fulfills the requirements to perform treatment planning in accordance with section 245I.10, subdivisions 7 and 8.

(d) A license holder under this section is exempt from certification as a mental health clinic under section 245I.20.

Subd. 10. **Outpatient substance use disorder care.** (a) When a license holder provides substance use disorder treatment services to an individual with a substance use disorder diagnosis, the license holder must comply with the requirements for substance use disorder services in chapter 245G, except as provided in this subdivision.

(b) A preliminary screening and risk assessment under this section fulfills the requirements to perform an initial services plan under section 245G.04, subdivision 1.

(c) A comprehensive evaluation under this section fulfills the requirements to perform a comprehensive assessment under section 245G.05.

(d) An integrated treatment plan under this section and containing a six-dimension analysis of the client's needs according to the third edition of ASAM criteria, as defined in section 254B.01, subdivision 2a, fulfills the requirements to provide an individual treatment plan under section 245G.06.

(e) A license holder under this section fulfills the requirement to document personnel files under section 245G.13, subdivision 3, by complying with the requirements of this chapter.

(f) A license holder under this section fulfills the requirement to protect client rights under section 245G.15 by complying with the requirements of section 245I.12.

(g) A license holder under this section fulfills the requirements to respond to behavioral emergencies under section 245G.16 by complying with the requirements of section 245I.03, subdivision 4.

(h) A license holder under this section is exempt from licensure under chapter 245G.

Subd. 11. **Initial triage and risk assessment.** (a) A license holder must have policies and procedures on:

(1) how staff will implement the requirements of this subdivision;

(2) staff positions authorized to complete triage and risk assessments;

(3) documenting the results of the risk screenings; and

(4) ensuring the client is offered timely services according to the federal CCBHC criteria.

(b) A license holder must conduct an initial triage and risk assessment when a new client requests services or is referred to services. A license holder may conduct an initial triage and risk assessment in person, by telephone, or other remote communication. Based on the acuity of needs as assessed in the initial triage and risk assessment, the client must be categorized as having emergency, urgent, or routine needs.

(c) Based on these categorizations, the license holder must offer services that meet the relevant timelines under the federal CCBHC criteria.

(d) The license holder must provide training that addresses:

(1) when a prospective client requires intervention from qualified staff;

(2) use of standardized measures that screen for significant risks;

(3) other factors that indicate a client has urgent needs besides the Columbia Suicide Severity Rating Scale or a self-harm screening; and

(4) overdose and substance use disorder risks.

Subd. 12. **Initial and comprehensive evaluation.** (a) A license holder under this section must provide initial and comprehensive evaluations according to this section and federal CCBHC criteria.

(b) An initial evaluation is necessary to authorize the provision of all medically necessary CCBHC services until the completion of a comprehensive evaluation. A comprehensive evaluation is necessary to authorize the provision of all medically necessary CCBHC services on an ongoing basis. A license holder must ensure that each client's comprehensive evaluation reflects the needs and assessments for all services provided.

Subd. 13. **Integrated treatment plan.** (a) A license holder under this section must complete an integrated treatment plan for each client following the comprehensive evaluation and no later than 60 calendar days after the date of the first request for services.

(b) A license holder must reflect all required services under subdivision 9 within the integrated treatment plan according to the client's needs.

(c) A license hold must review and update a client's treatment plan as necessary to reflect the changing needs of the client and progress made in treatment. If the client has not made treatment progress, the revision of the treatment plan must indicate changes in the license holder's approach to treatment to better meet the needs of the client. A license holder must review and update the treatment plan at least every 180 days or as clinically indicated.

Subd. 14. **Psychiatric rehabilitation services.** (a) For children, a license holder under this section must provide children's therapeutic services and supports according to sections 245I.30 and 245I.31, except that an initial or comprehensive assessment under this section fulfills the requirement to perform a standard diagnostic assessment.

(b) For adults, a license holder under this section must provide adult rehabilitative mental health services according to section 245I.22, except that:

(1) the license holder is exempt from the requirement to perform a level of care assessment under section 245I.22, subdivision 6, paragraph (b); and

(2) an initial or comprehensive assessment under this section fulfills the requirement to perform a standard diagnostic assessment.

Subd. 15. **Community-based care for veterans.** (a) The license holder must provide services according to federal requirements for eligibility and coordination with TRICARE and the United States Department of Veterans Affairs.

(b) The license holder must assign and document a principal behavioral health provider for every veteran receiving services.

Subd. 16. **Primary care screening and monitoring.** To fulfill the requirements for primary care screening, a license holder under this section must have policies and procedures detailing the screenings to be performed with specific populations at the clinic. The policies and procedures must be approved by the medical director.

Subd. 17. **Peer services.** A license holder must be able to provide peer services as described by federal CCBHC criteria and sections 245G.07, subdivision 2, clause (8), 256B.0615, and 256B.0616.

Subd. 18. **Targeted case management.** (a) A license holder must provide mental health targeted case management as described by federal CCBHC criteria and section 256B.0625, subdivision 20.

(b) An initial or comprehensive evaluation under this section fulfills any requirement to perform a standard diagnostic assessment.

Subd. 19. **Community needs assessment.** (a) The community needs assessment must be a collaborative document that reflects the engagement of the applicant or license holder with current clients, other social and medical services agencies, community groups, underserved populations, and government agencies. An applicant or license holder must document an outreach plan within the community needs assessment to demonstrate how stakeholder feedback was solicited and reflected in the plan.

(b) The applicant or license holder must publicly post a draft community needs assessment on the organization's website for 30 days and submit a summary of public comments and recommendations from the comment period to the commissioner.

(c) In the draft community needs assessment, the applicant or license holder must declare a planned geographic service delivery area in which the CCBHC will be capable of providing all nine required services. An applicant must show an analysis of how CCBHC status will make a significant improvement in the availability and quality of the services. An existing license holder must include analysis of which needs from prior needs assessments have been improved by the operation of the CCBHC. A clinic that has not made and demonstrated

substantial progress in addressing the identified needs must specify what changes will occur to address the lack of progress.

(d) The commissioner must provide feedback and technical assistance if the needs assessment must be revised.

Subd. 20. **Staffing plan.** (a) Based on an accepted community needs assessment, the applicant or license holder must complete a staffing plan. The staffing plan must include analysis of the extent to which identified staffing levels will be capable of meeting the needs identified in the community needs assessment.

(b) The commissioner must provide feedback and technical assistance if the needs assessment must be revised.

Subd. 21. **Data and evaluation.** A provider must submit documentation that establishes the ability of the clinic to complete the required data collection as a CCBHC, as determined by the commissioner. For an applicant that is an existing provider, the commissioner must review and evaluate data submitted related to claims, grants, and other reporting to ensure the data meets reporting requirements.

Subd. 22. **Cost reporting.** A provider must submit a cost report on the forms and in the manner required in section 256B.0625, subdivision 5m.

Sec. 32. **[245I.22] ADULT REHABILITATIVE MENTAL HEALTH SERVICES.**

Subdivision 1. **Generally.** Beginning January 1, 2028, a provider of adult mental health rehabilitative services must be licensed under this section and chapter 245A.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "Adult mental health rehabilitative services" or "ARMHS" has the meaning given in section 245I.02, subdivision 33.

(c) "Basic living skills" means rehabilitative interventions that instruct, assist, and support the client in areas, including interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, mental illness symptom management skills, household management skills, employment-related skills, and parenting skills.

(d) "Community intervention" means a client's community assisting in the client's rehabilitation and includes consultation with relatives, guardians, friends, employers,

treatment providers, and other significant individuals. Community intervention is appropriate when directed exclusively to the treatment of the client.

(e) "Medication education services" means services provided individually or in groups that focus on educating the client 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 must be coordinated with medication management services and not duplicate it. Medication education services must be provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(f) "Transition to community living" means services that maintain continuity of contact between the rehabilitation services provider and the client and facilitate discharge from a hospital, residential treatment program, board and lodging facility, or nursing home. Transition to community living services must not be used to provide other areas of adult rehabilitative mental health services.

Subd. 3. **Service components.** An ARMHS provider must be capable of providing:

(1) basic living skills;

(2) medication education;

(3) community intervention; and

(4) transition to community living.

Subd. 4. **Provider requirements.** An ARMHS license holder must be enrolled with medical assistance and comply with standards in section 256B.0623.

Subd. 5. **Qualifications.** ARMHS must be provided by:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

(3) a clinical trainee qualified under section 245I.04, subdivision 6;

(4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

(5) a mental health certified peer specialist qualified under section 245I.04, subdivision 12; or

(6) a mental health rehabilitation worker qualified under section 245I.04, subdivision 14.

Subd. 6. **Service planning.** (a) A provider of ARMHS must complete a written functional assessment according to section 245I.10, subdivision 9, for each client.

(b) When a provider of ARMHS 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 client.

Subd. 7. **Group modality.** ARMHS may be provided in group settings if appropriate to each participating client's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is concurrently receiving ARMHS. The service and group must be specified in the client's individual treatment plan.

Sec. 33. **[245I.24] MOBILE CRISIS RESPONSE SERVICES.**

Subdivision 1. **Generally.** (a) Mobile crisis response services provide short-term, face-to-face mental health care for adults and children experiencing crisis in community settings to help the individual maintain safety and return to a baseline level of functioning.

(b) Beginning January 1, 2028, a provider of mobile crisis response services must be licensed under this section and chapter 245A.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "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 5.

(c) "Crisis intervention" means face-to-face, short-term intensive mental health services initiated during a mental health crisis to help the individual cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the individual's baseline level of functioning.

(d) "Crisis screening" means a screening of a client's potential mental health crisis situation under subdivision 6.

(e) "Crisis stabilization" means individualized mental health services provided to an individual that are designed to restore the individual to the individual's baseline level of functioning. Crisis stabilization services may be provided in the individual's home, the home of a family member or friend of the individual, another community setting, a short-term supervised licensed residential program, or an emergency department. Crisis stabilization services include family psychoeducation.

(f) "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.

(g) "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 individual's levels of functioning in primary activities of daily living, the individual needing emergency services under section 62Q.55, or the individual being placed in a more restrictive setting, including but not limited to inpatient hospitalization.

(h) "Mobile crisis services" means screening, assessment, intervention, and community-based stabilization that is provided to an individual client. Mobile crisis services does not include residential crisis stabilization.

Subd. 3. **Eligibility.** (a) An individual is eligible for crisis assessment services when the person has screened positive for a potential mental health crisis during a crisis screening.

(b) An individual is eligible for crisis intervention services and crisis stabilization services when the individual has been assessed during a crisis assessment to be experiencing a mental health crisis.

Subd. 4. **Policies, procedures, and practices specified.** (a) In addition to the policies and procedures required by section 245I.03, the license holder must establish, enforce, and maintain policies and procedures to:

(1) ensure that crisis screenings, assessments, and intervention services are available 24 hours per day, seven days per week;

(2) respond to a call for services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area;

(3) have at least one mental health professional on staff at all times and at least one additional staff member capable of leading a crisis response in the community; and

(4) respond to clients in the community according to the requirements and priorities in subdivision 6.

(b) The license holder must provide the commissioner with information about the number of requests for service, the number of clients that the provider serves face-to-face, and client outcomes a minimum of every six months.

(c) The license holder must:

(1) provide support for an individual's family and natural supports by enabling the individual's family and natural supports to observe and participate in the individual's treatment, assessments, and planning services;

(2) implement culturally specific treatment identified in the crisis treatment plan that is meaningful and appropriate as determined by the individual's culture, beliefs, values, and language;

(3) respond to the changing intervention and care needs of an individual as identified by the individual or a family member; and

(4) have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur.

(d) The license holder must coordinate services with:

(1) county emergency services under section 245.469, community hospitals, ambulance, transportation services, social services, law enforcement, engagement services, and mental health crisis services through regularly scheduled interagency meetings;

(2) other behavioral health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the individual or parent or guardian;

(3) detoxification, withdrawal management services, and medical stabilization services as required by clients; and

(4) the individual's case manager if the individual is receiving case management services.

Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Crisis assessment and intervention services must be provided by:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a clinical trainee qualified under section 245I.04, subdivision 6;

(3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

(4) a mental health certified family peer specialist qualified under section 245I.04, subdivision 12; or

(5) a mental health certified peer specialist qualified under section 245I.04, subdivision 10.

(b) When crisis assessment and intervention services are provided to an individual in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) For providers under this section, 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 individual's risk of suicide and self-injurious behavior.

(d) At least six hours of the ongoing training under paragraph (c) must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

(e) Individual providers 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) A license holder may use the resources of emergency services under section 245.469 for crisis screening. 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 a crisis screening, a provider must:

(1) employ evidence-based practices to reduce the individual's risk of suicide and self-injurious behavior;

(2) work with the individual to establish a plan and time frame for responding to the individual's mental health crisis, including responding to the individual's immediate need for support by telephone or text message until the provider can respond to the individual face-to-face;

(3) document significant factors in determining whether the individual is experiencing a mental health crisis, including prior requests for crisis services, an individual's recent

presentation at an emergency department, known calls to 911 or law enforcement, or information from third parties with knowledge of an individual'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 individual; and

(6) consider other available services to determine which service intervention would best address the individual'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 individual, unless a provider documents specific evidence to show why the face-to-face assessment was not possible, including insufficient staffing resources, concerns for staff or individual safety, or other clinical factors:

(1) the individual 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 an individual who is potentially subject to transportation under section 253B.051.

(d) A provider is not required to have direct contact with the individual to determine that the individual is experiencing a potential mental health crisis. A mobile crisis provider may gather relevant information about the individual from a third party to establish the individual's need for services and potential safety factors.

Subd. 7. **Crisis assessment.** (a) If an individual screens positive for a potential mental health crisis, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which services are needed and, as time permits, the individual's:

(1) current life situation;

(2) health information, including current medications;

(3) sources of stress;

(4) mental health problems and symptoms;

(5) strengths;

(6) cultural considerations;

(7) support network;

(8) vulnerabilities;

(9) current functioning; and

(10) preferences as communicated directly by the individual or as communicated in a health care directive as described in chapters 145C and 253B, the crisis treatment plan described in subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

(b) A provider must conduct a crisis assessment at the individual's location when appropriate and, when not appropriate, document the reasons.

(c) Whenever possible, the assessor must attempt to include input from the individual and the individual's family and other natural supports to assess whether a crisis exists.

(d) A crisis assessment includes determining whether the individual is willing to voluntarily engage in treatment, whether the individual has an advance directive, and gathering the individual's information and history from involved family or other natural supports.

(e) If the individual does not need an acute level of care, a team must serve an otherwise eligible individual who has a co-occurring substance use disorder.

(f) If after completing a crisis assessment of an individual, a provider refers the individual 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 individual'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 individual's referral. Following the consultation, the provider must also send written documentation to the referral entity upon completion. The provider must document if the individual or the individual's legal guardian signed releases for health records or if an exception under section 144.293, subdivision 5, exists.

Subd. 8. **Crisis intervention services.** (a) If the crisis assessment determines an individual needs mobile crisis intervention services, the license holder must provide crisis intervention services 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 10.

(b) If a provider delivers crisis intervention services while the individual is absent, the provider must document the reason for delivering services while the individual 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 individual's mental health crisis is stabilized, but the individual needs a referral to other services, the team must provide referrals to these services. If the individual is unable to follow up on the referral, the team must link the individual to the service and follow up to ensure the individual is receiving the service.

Subd. 9. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity which must:

(1) develop a crisis treatment plan that meets the criteria in subdivision 11;

(2) complete a vulnerable adult determination in accordance with section 245A.65, subdivision 1a;

(3) deliver crisis stabilization services according to the crisis treatment plan and include face-to-face contact with the individual receiving services 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;

(4) if the provider delivers crisis stabilization services while the individual is absent, document the reason for delivering services while the individual is absent; and

(5) if the individual's mental health crisis is stabilized and the individual does not have a health care directive or psychiatric declaration, as defined in chapter 145C or section 253B.03, subdivision 6d, offer to work with the individual to develop a directive or declaration.

(b) A staff member providing crisis stabilization services must be:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

(3) a clinical trainee qualified under section 245I.04, subdivision 6;

(4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

(5) a mental health certified family peer specialist qualified under section 245I.04, subdivision 12;

(6) a mental health certified peer specialist qualified under section 245I.04, subdivision 10; or

(7) a mental health rehabilitation worker qualified under section 245I.04, subdivision 14.

(c) For providers under this section, 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 an individual's risk of suicide and self-injurious behavior.

(d) For providers who deliver care to children 21 years of age or 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, including 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 services providers licensed under section 245I.23 or providing services pursuant to section 256B.0624, subdivision 7a.

Subd. 10. **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 license holder must accept full responsibility for the services provided;

(2) a mental health professional working for the license holder must be immediately available by telephone or in person for treatment supervision;

(3) a mental health professional must be consulted, in person or by telephone, during the first three hours when a clinical trainee or mental health practitioner provides crisis assessment or crisis intervention services; and

(4) a mental health professional must:

(i) review and approve, as defined in section 245I.02, subdivision 2, the tentative crisis assessment and crisis treatment plan within 24 hours of first providing services to the individual, 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 an individual's admission, the license holder must complete the individual's crisis treatment plan. The license holder must:

(1) base the individual's crisis treatment plan on the individual's crisis assessment;

(2) consider crisis assistance strategies that have been effective for the individual in the past;

(3) for a child, use a child-centered, family-driven, and culturally appropriate planning process that allows the child's parents and guardians to observe or participate in the child's individual and family treatment services, assessment, and treatment planning;

(4) for an adult, use a person-centered, culturally appropriate planning process that allows the individual's family and other natural supports to observe or participate in treatment services, assessment, and treatment planning;

(5) identify the participants involved in the individual's treatment planning. The individual must be a participant if possible;

(6) identify the individual's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the person engage in treatment;

(7) include documentation of referral to and scheduling of services, including specific providers where applicable;

(8) ensure that the individual or the individual's legal guardian approves under section 245I.02, subdivision 2, of the individual's crisis treatment plan unless a court orders the individual's treatment plan under chapter 253B. If the individual or the individual's legal guardian disagrees with the crisis treatment plan, the license holder must document in the client file the reasons why the individual disagrees with the crisis treatment plan; and

(9) ensure that a treatment supervisor approves, as defined in section 245I.02, subdivision 2, of the individual's treatment plan within 24 hours of the individual'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 individual and the individual's legal guardian with a copy of the crisis treatment plan.

Subd. 12. **Application requirements.** In an application made under this section and section 245A.04, the applicant must demonstrate that the applicant is:

(1) enrolled as a medical assistance provider; and

(2) in compliance with the provider type requirements under section 256B.0624, subdivision 4, as determined by the commissioner.

Sec. 34. **[245I.30] CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS IN THE COMMUNITY.**

Subdivision 1. **Generally.** (a) "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. The services are interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan. Children's therapeutic services and supports include development and rehabilitative services that support a child's developmental treatment needs.

(b) Beginning January 1, 2028, a provider of children's therapeutic services and supports in the community must be licensed under this section and chapter 245A.

Subd. 2. **Service components.** (a) A children's therapeutic services and supports license holder must be capable of providing:

(1) individual and family psychotherapy, psychotherapy for crises, and group psychotherapy;

(2) individual, family, or group skills training; and

(3) crisis planning.

(b) Crisis planning that meets the standards in section 245.4871, subdivision 9a, must be offered to each client's family.

Subd. 3. **Provider requirements.** A children's therapeutic services and supports license holder must be enrolled with medical assistance and comply with the requirements in section 256B.0943.

Subd. 4. **Qualifications of provider staff.** Children's therapeutic services and supports must be provided by:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a clinical trainee qualified under section 245I.04, subdivision 6;

(3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

(4) a mental health certified family peer specialist qualified under section 245I.04, subdivision 12; or

(5) a mental health behavioral aide qualified under section 245I.04, subdivision 16.

Subd. 5. **Group modality.** Group skills training may be provided to multiple clients who, because of the nature of the clients' emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting. A group is defined as two to ten clients, at least one of whom is a client and is concurrently receiving a service under this section. The service and group must be specified in the client's individual treatment plan.

Sec. 35. **[245I.31] CHILDREN'S DAY TREATMENT.**

Subdivision 1. **Generally.** (a) For the purposes of this section, "children's day treatment program" means a site-based structured mental health program consisting of psychotherapy and individual or group skills training provided by a team under the treatment supervision of a mental health professional.

(b) Children's day treatment programs are licensed for a specific location of operation and are not part of inpatient or residential treatment services.

(c) A children's day treatment program must stabilize a 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.

(d) Beginning January 1, 2028, a provider of children's day services must be licensed under this section and chapter 245A.

Subd. 2. **Service components.** A children's day treatment program must be capable of providing the services in section 245I.30, subdivision 2.

Subd. 3. **Provider requirements.** A children's day treatment license holder must:

(1) be enrolled as a provider with medical assistance;

(2) maintain a policy regarding the use of restrictive procedures and meet the requirements of section 245.8261;

(3) maintain a policy on medications in accordance with section 245I.11, subdivision 6; and

(4) meet group modality requirements in section 245I.30, subdivision 5.

Subd. 4. **Qualifications of provider staff.** Children's day treatment services must be provided by:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a clinical trainee qualified under section 245I.04, subdivision 6; or

(3) a behavioral health practitioner qualified under section 245I.04, subdivision 4.

Sec. 36. Minnesota Statutes 2024, section 256B.0623, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically necessary adult rehabilitative mental health services when the services are provided by an entity ~~meeting the standards in this section~~ licensed under section 245I.24. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 37. Minnesota Statutes 2024, section 256B.0623, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245I.10, subdivision 9, paragraph (a), clause (4), so that self-sufficiency is markedly reduced; and

(4) has had a recent standard diagnostic assessment pursuant to section 245I.10, subdivision 6, by a qualified professional that documents adult rehabilitative mental health

services are medically necessary to address identified disability and functional impairments and individual recipient goals.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 38. Minnesota Statutes 2024, section 256B.0623, subdivision 12, is amended to read:

Subd. 12. **Additional requirements.** ~~(a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.~~

~~(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community.~~ (a) Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or section 245I.23, or an acute care hospital.

~~(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and individual treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's individual treatment plan.~~ (b) No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

~~(d)~~ (c) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

~~(e) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas including: interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.~~

~~(f) Community intervention, including consultation with relatives, guardians, friends, employers, treatment providers, and other significant individuals, is appropriate when directed exclusively to the treatment of the client.~~

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 39. Minnesota Statutes 2024, section 256B.0624, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically necessary crisis response services when the services are provided according to the standards in ~~this~~ section 245I.24.

(b) ~~Subject to federal approval,~~ Medical assistance covers medically necessary residential crisis stabilization for adults when the services are provided by an entity licensed under and meeting the standards in section 245I.23 or an entity with an adult foster care license meeting the standards in ~~this section~~ subdivision 7a.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols approved by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 40. Minnesota Statutes 2024, section 256B.0624, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) A mobile crisis provider must be:

(1) a county board operated entity;

(2) an Indian health services facility or facility owned and operated by a tribe or Tribal organization operating under United States Code, title 325, section 450f; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

~~(b) A mobile crisis provider must meet the following standards:~~

~~(1) ensure that crisis screenings, crisis assessments, and crisis intervention services are available to a recipient 24 hours a day, seven days a week;~~

~~(2) be able to respond to a call for services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area;~~

~~(3) have at least one mental health professional on staff at all times and at least one additional staff member capable of leading a crisis response in the community; and~~

~~(4) provide the commissioner with information about the number of requests for service, the number of people that the provider serves face-to-face, outcomes, and the protocols that the provider uses when deciding when to respond in the community.~~

~~(c) A provider entity that provides crisis stabilization services in a residential setting under subdivision 7 is not required to meet the requirements of paragraphs (a) and (b), but must meet all other requirements of this subdivision.~~

~~(d) A crisis services provider must have the capacity to meet and carry out the standards in section 245I.011, subdivision 5, and the following standards:~~

~~(1) ensures that staff persons provide support for a recipient's family and natural supports, by enabling the recipient's family and natural supports to observe and participate in the recipient's treatment, assessments, and planning services;~~

~~(2) has adequate administrative ability to ensure availability of services;~~

~~(3) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;~~

~~(4) is able to ensure that staff are implementing culturally specific treatment identified in the crisis treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;~~

~~(5) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient or family member during the service partnership between the recipient and providers;~~

~~(6) is able to ensure that staff have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;~~

~~(7) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, engagement services, and mental health crisis services through regularly scheduled interagency meetings;~~

~~(8) is able to ensure that services are coordinated with other behavioral health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the recipient or parent or guardian.~~

~~Services must also be coordinated with the recipient's case manager if the recipient is receiving case management services;~~

~~(9) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486 and 245.487 to 245.4879;~~

~~(10) is able to coordinate detoxification services for the recipient according to Minnesota Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;~~

~~(11) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction; and~~

~~(12) is an enrolled medical assistance provider.~~

(b) A mobile crisis provider must ensure services are provided consistent with section 245.469, subdivisions 1 and 2.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 41. Minnesota Statutes 2024, section 256B.0624, is amended by adding a subdivision to read:

Subd. 7a. **Residential crisis stabilization services in adult foster care settings.** (a) 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 must establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner must set rates prospectively for the annual rate period. The commissioner must require providers to submit annual cost reports on a uniform cost reporting form and use submitted cost reports to inform the rate-setting process. The commissioner must recalculate the statewide per diem every year.

(b) A provider under this subdivision must follow the requirements under section 245I.24, subdivisions 4, paragraphs (c) and (d), and 9.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 42. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of section ~~245.735, subdivision 3~~ 245I.17.

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

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

(1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section ~~245.735, subdivision 3, paragraph (a), clauses (6) and (7)~~ 245I.17, subdivision 4; and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section ~~245.735, subdivision 3, paragraph (a), clause (6)~~ 245I.17, subdivision 4, is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly ~~certified~~ licensed CCBHCs under section ~~245.735, subdivision 3~~ 245I.17, shall be established by the commissioner using a provider-specific rate based on the newly ~~certified~~ licensed CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change

in the scope of services. For CCBHCs certified after September 30, 2020, and before January 1, 2021, the commissioner shall rebase rates according to this clause for services provided on or after January 1, 2024;

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

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

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

(8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

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

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

in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

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

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

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

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

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

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

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

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

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

(g) Peer services provided by a CCBHC ~~certified~~ licensed under section ~~245.735~~ 245I.17 are a covered service under medical assistance when a licensed mental health professional or alcohol and drug counselor determines that peer services are medically necessary. Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph (b), clause (2).

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 43. Minnesota Statutes 2024, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports when the services are provided by an eligible provider entity ~~certified under and meeting the standards in this section~~ licensed under section 245I.30 or children's day treatment services licensed under section 245I.31. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) The covered service components of children's therapeutic services and supports are:

~~(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;~~

~~(2) individual, family, or group skills training provided by a mental health professional, clinical trainee, or mental health practitioner;~~

~~(3) crisis planning;~~

~~(4) mental health behavioral aide services;~~

(1) the services described in section 245I.30, subdivision 2, by providers licensed under section 245I.30 or 245I.31;

(2) administration of standardized measures;

~~(5)~~ (3) direction of a mental health behavioral aide; and

~~(6)~~ (4) mental health service plan development~~; and~~.

~~(7) children's day treatment.~~

(c) In delivering services under this section, a licensed provider entity must ensure that psychotherapy to address a child's underlying mental health disorder is 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 the psychotherapy or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record.

(d) Medical assistance covers service plan development before completion of a child's individual treatment plan. Service plan development consists of development, review, and revision of the individual treatment plan by face-to-face or electronic communication, including time spent gathering client history from other key figures or providers. 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. Service plan development is covered only if a treatment plan is completed or for work already completed at the time the client voluntarily chooses to disengage with services for the child. If it is determined upon review that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

(e) Medical assistance covers time spent administering and reporting standardized measures approved by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 44. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a clinical trainee that is performed within one year before the initial start of service and updated as required under section 245I.10, subdivision 2. The standard diagnostic assessment must:

(1) determine whether ~~a child under age 18 has a diagnosis of mental illness or, if the person is between the ages of 18 and 21, whether~~ the person has a mental illness; and

(2) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals~~; and~~.

~~(3) be used in the development of the individual treatment plan.~~

(b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

~~(c) Children's therapeutic services and supports include development and rehabilitative services that support a child's developmental treatment needs.~~

Sec. 45. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** (a) The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) treatment by multiple providers within the same agency at the same clock time, unless one service is delivered to the child and the other service is delivered to the child's family or treatment team without the child present;

(3) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(5) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(iii) prevention or education programs provided to the community; and

(iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

(b) Time spent doing work before and after providing direct services, including scheduling or maintaining clinical records, is included in CTSS payments and may not be separately billed as additional clock hours of service.

Sec. 46. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended to read:

Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency responsible for investigating allegations of maltreatment in child foster care, family child care, legally nonlicensed child care, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A and 245D.

(c) The Department of Health is the agency responsible for screening and investigating allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H.

(d) The Department of Education is the agency responsible for screening and investigating allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E. The Department of Education's responsibility to screen and investigate includes allegations of maltreatment involving students 18 through 21 years of age, including students receiving special education services, up to and including graduation and the issuance of a secondary or high school diploma.

(e) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors in an EIDBI agency operating under sections 245A.142 and 256B.0949.

(f) A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

(g) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in facilities or programs not listed in paragraph (a) that are licensed or certified under chapters 142B and 142C.

(h) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors for mobile crisis response services and children's therapeutic services and supports programs licensed under chapter 245I.

Sec. 47. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, EIDBI agencies, family adult day services, mental health programs licensed under chapter 245I, mental health clinics, substance use disorder programs, the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services. The Department of Human Services is also the lead investigative agency for unlicensed EIDBI agencies under section 256B.0949. The Department of Human Services is the lead investigative agency for adult rehabilitative mental health services under section 245I.22, mobile crisis response services under section 245I.24, and certified community behavioral health clinics under section 245I.17.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including but not limited to reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 48. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245.735, subdivisions 5 and 6, as Minnesota Statutes, section 245I.17, subdivisions 23 and 24.

Sec. 49. **REPEALER.**

(a) Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, and 8; 245C.03, subdivision 7; 245I.20, subdivision 9; 245I.23, subdivision 23; 256B.0623, subdivisions 2, 4, 5, 6, and 9; 256B.0624, subdivisions 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9, and 11; and 256B.0943, subdivisions 4, 5, 5a, 6, 7, and 11, are repealed.

(b) Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3 and 4d; and 256B.0943, subdivisions 1 and 9, are repealed.

EFFECTIVE DATE. This section is effective January 1, 2028.

ARTICLE 6
BACKGROUND STUDIES

Section 1. Minnesota Statutes 2025 Supplement, section 142A.09, subdivision 1, is amended to read:

Subdivision 1. **Background studies required.** The commissioner of human services shall conduct background studies of individuals specified in section 245C.03~~, subdivision 5c,~~ affiliated with:

(1) a facility or program licensed or seeking a license under chapter 142B;

(2) a license-exempt child care center certified under chapter 142C; or

(3) a legal nonlicensed child care provider authorized under chapter 142E.

Sec. 2. Minnesota Statutes 2025 Supplement, section 142B.05, subdivision 3, is amended to read:

Subd. 3. **Foster care by an individual who is related to a child; license required.** (a) Notwithstanding subdivision 2, paragraph (a), clause (1), in order to provide foster care for a child, an individual who is related to the child, other than a parent, or legal guardian, must be licensed by the commissioner except as provided by section 142B.06.

(b) If an individual who is related to a child is seeking licensure to provide foster care for the child and the individual has a domestic partner but is not married to the domestic partner, only the individual related to the child must be licensed to provide foster care. The commissioner must conduct background studies on household members according to section 245C.03~~, subdivision 1~~.

Sec. 3. Minnesota Statutes 2025 Supplement, section 142B.10, subdivision 14, is amended to read:

Subd. 14. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 142B.11. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

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

(4) the type of license;

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

(6) any special conditions of licensure.

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

(1) the commissioner is unable to conduct the observation required by subdivision 11, paragraph (a), clause (3), because the program is not yet operational;

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

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

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

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

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

(2) been denied a license under this chapter or chapter 245A within the past two years;

(3) had a license issued under this chapter or chapter 245A revoked within the past five years; or

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

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

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

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

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

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

(i) Pursuant to section 142B.18, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

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

(k) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

(l) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must comply with the requirements in section 142B.12 and be reissued a new license to operate the program or the program must not be operated after the expiration date. Child foster care license holders must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

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

(n) The commissioner of children, youth, and families shall coordinate and share data with the commissioner of human services to enforce this section.

Sec. 4. Minnesota Statutes 2024, section 142B.15, is amended to read:

142B.15 DENIAL OF APPLICATION.

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

(1) fails to submit a substantially complete application after receiving notice from the commissioner under section 142B.10, subdivision 1;

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

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

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

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

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

(7) fails to comply with section 142B.10, subdivision 1, paragraph (f) or (g);

(8) fails to demonstrate competent knowledge as required by section 142B.10, subdivision 13;

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

(10) is prohibited from holding a license according to section 142A.12 or 245.095; or

(11) for a family foster setting, has or has an individual who is living in the household where the licensed services are provided or is otherwise subject to a background study who has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the applicant's ability to safely provide care to foster children.

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice must be given by certified mail, by personal service, or through the provider licensing and reporting hub. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. If the order is issued through the provider hub, the appeal must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. Section 142B.20 applies to hearings held to appeal the commissioner's denial of an application.

Sec. 5. Minnesota Statutes 2024, section 142B.79, is amended to read:

142B.79 CONTRACTORS SERVING MULTIPLE FAMILY CHILD CARE LICENSE HOLDERS.

Contractors who serve multiple family child care license holders may request that the county agency maintain a record of:

(1) the contractor's background study results as required in section 245C.04~~, subdivision 8,~~ to verify that the contractor does not have a disqualification or a disqualification that has not been set aside, and is eligible to provide direct contact services in a licensed program; and

(2) the contractor's compliance with training requirements.

Sec. 6. Minnesota Statutes 2024, section 144.057, subdivision 1, is amended to read:

Subdivision 1. **Background studies required.** (a) Except as specified in paragraph (b), the commissioner of health shall contract with the commissioner of human services to conduct background studies of:

(1) individuals providing services that have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; assisted living facilities and assisted living facilities with dementia care licensed under chapter 144G; and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

(2) individuals specified in section 245C.03~~, subdivision 1,~~ who perform direct contact services in a nursing home or a home care agency licensed under chapter 144A; an assisted living facility or assisted living facility with dementia care licensed under chapter 144G; or a boarding care home licensed under sections 144.50 to 144.58. If the individual under study resides outside Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the information is made available by that state, and must include a check of the National Crime Information Center database;

(3) all other employees in assisted living facilities or assisted living facilities with dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;

(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities;

(5) controlling persons of a supplemental nursing services agency, as defined under section 144A.70; and

(6) license applicants, owners, managerial officials, and controlling individuals who are required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a background study under chapter 245C, regardless of the licensure status of the license applicant, owner, managerial official, or controlling individual.

(b) The commissioner of human services shall not conduct a background study on any individual identified in paragraph (a), clauses (1) to (5), if the individual has a valid license issued by a health-related licensing board as defined in section 214.01, subdivision 2, and

has completed the criminal background check as required in section 214.075. An entity that is affiliated with individuals who meet the requirements of this paragraph must separate those individuals from the entity's roster for NETStudy 2.0.

(c) If a facility or program is licensed by the Department of Human Services and subject to the background study provisions of chapter 245C and is also licensed by the Department of Health, the Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed programs.

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

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

(1) the name of the license holder;

(2) the address of the program;

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

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

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

(6) any special conditions of licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

245A.05 DENIAL OF APPLICATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2025 Supplement, section 245C.02, subdivision 15a, is amended to read:

Subd. 15a. **Reasonable cause to require a national criminal history record check.** (a) "Reasonable cause to require a national criminal history record check" means information or circumstances exist that provide the commissioner with articulable suspicion that further pertinent information may exist concerning a background study subject that merits conducting a national criminal history record check on that subject. The commissioner has reasonable cause to require a national criminal history record check when:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined;

(3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota; or

(4) information from the Bureau of Criminal Apprehension for a state-based name and date of birth background study in which the subject is a minor that indicates that the subject has a criminal history.

(b) In addition to the circumstances described in paragraph (a), the commissioner has reasonable cause to require a national criminal history record check if the subject is not currently residing in Minnesota or resided in a jurisdiction other than Minnesota during the previous five years.

(c) Reasonable cause to require a national criminal history check does not apply to family child foster care ~~or~~, adoption, adult day services, or adult foster care studies.

EFFECTIVE DATE. This section is effective January 25, 2028.

Sec. 10. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Programs licensed by the commissioner.** (a) The commissioner shall conduct a background study when initiated on the following individuals affiliated with programs licensed by the commissioner:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees of the applicant or license holder who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15; and

(7) all controlling individuals as defined in section 245A.02, subdivision 5a;

(8) notwithstanding clause (3), for children's residential facilities and foster residence settings, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

(b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

(c) This subdivision applies to the following programs that must be licensed under chapter 245A:

(1) adult foster care;

(2) children's residential facilities;

(3) licensed home and community-based services under chapter 245D;

(4) residential mental health programs for adults;

(5) substance use disorder treatment programs under chapter 245G;

(6) withdrawal management programs under chapter 245F;

(7) adult day care centers;

(8) family adult day services;

(9) detoxification programs;

(10) community residential settings;

(11) intensive residential treatment services and residential crisis stabilization under chapter 245I; and

(12) treatment programs for persons with sexual psychopathic personality or sexually dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts 9515.3000 to 9515.3110.

Sec. 11. Minnesota Statutes 2024, section 245C.03, subdivision 2, is amended to read:

Subd. 2. **Personal care provider organizations.** The commissioner shall conduct background studies on any individual ~~required under sections 256B.0651 to 256B.0654 and 256B.0659 to have a background study completed under this chapter~~ with at least a five percent ownership stake in, an operator of, or an employee or volunteer who provides direct contact services for a personal care provider organization under section 256B.0659. For the purposes of this subdivision, operator includes board members or other individuals who oversee the billing, management, or policies of the services provided.

Sec. 12. Minnesota Statutes 2024, section 245C.03, subdivision 3, is amended to read:

Subd. 3. **Supplemental nursing services agencies.** The commissioner shall conduct ~~all~~ background studies ~~required under this chapter and initiated by~~ on any individual who is an owner with at least a five percent ownership stake in, an operator of, or an employee or volunteer who provides direct contact services for a supplemental nursing services ~~agencies registered~~ agency under section 144A.71, subdivision 1. For the purposes of this subdivision, operator includes board members or other individuals who oversee the billing, management, or policies of the services provided.

Sec. 13. Minnesota Statutes 2024, section 245C.03, subdivision 4, is amended to read:

Subd. 4. **Personnel pool agencies; temporary personnel agencies; educational programs; professional services agencies.** (a) The commissioner ~~also may~~ shall conduct studies on ~~individuals specified in subdivision 1, paragraph (a), clauses (3) and (4),~~ employees or volunteers seeking to provide direct contact services for programs licensed by the commissioner of human services or health when the studies are initiated by:

(1) personnel pool agencies;

(2) temporary personnel agencies;

(3) educational programs that train individuals by providing direct contact services in licensed programs; and

(4) professional services agencies that are not licensed and that work with licensed programs to provide direct contact services or individuals who provide direct contact services.

(b) Personnel pool agencies, temporary personnel agencies, and professional services agencies must employ the individuals providing direct care services for children, people with disabilities, or the elderly. Individuals must be affiliated in NETStudy 2.0 and subject to oversight by the entity, which includes but is not limited to continuous, direct supervision by the entity and being subject to immediate removal from providing direct care services when required.

Sec. 14. Minnesota Statutes 2024, section 245C.03, subdivision 5a, is amended to read:

Subd. 5a. **~~Facilities~~ Programs serving children or adults licensed or regulated by the Department of Health.** (a) Except as specified in paragraph (b), the commissioner shall conduct background studies under this chapter of:

(1) ~~individuals providing services who have direct contact, as defined under section 245C.02, subdivision 11, with patients and residents in~~ any individual with at least a five percent ownership stake in, an operator of, or an employee or volunteer who provides direct contact services for hospitals, boarding care homes, outpatient surgical centers licensed under sections 144.50 to 144.58; nursing homes and home care agencies licensed under chapter 144A; assisted living facilities and assisted living facilities with dementia care licensed under chapter 144G; and board and lodging establishments that are registered to provide supportive or health supervision services under section 157.17;

(2) ~~individuals specified in subdivision 2 who provide direct contact services in a~~ any individual with at least a five percent ownership stake in, an operator of, or an employee or

volunteer who provides direct contact services for nursing home or a home care agency licensed under chapter 144A; an assisted living facility or assisted living facility with dementia care licensed under chapter 144G; or a boarding care home licensed under sections 144.50 to 144.58. If the individual undergoing a study resides outside of Minnesota, the study must include a check for substantiated findings of maltreatment of adults and children in the individual's state of residence when the state makes the information available; and

(3) ~~all other employees in~~ any individual with at least a five percent ownership stake in, an operator of, or an employee or volunteer who provides direct contact services for assisted living facilities or assisted living facilities with dementia care licensed under chapter 144G, nursing homes licensed under chapter 144A, and boarding care homes licensed under sections 144.50 to 144.58. ~~A disqualification of an individual in this section shall disqualify the individual from positions allowing direct contact with or access to patients or residents receiving services. "Access" means physical access to a client or the client's personal property without continuous, direct supervision as defined in section 245C.02, subdivision 8, when the employee's employment responsibilities do not include providing direct contact services;~~

~~(4) individuals employed by a supplemental nursing services agency, as defined under section 144A.70, who are providing services in health care facilities;~~

~~(5) controlling persons of a supplemental nursing services agency, as defined by section 144A.70; and~~

~~(6) license applicants, owners, managerial officials, and controlling individuals who are required under section 144A.476, subdivision 1, or 144G.13, subdivision 1, to undergo a background study under this chapter, regardless of the licensure status of the license applicant, owner, managerial official, or controlling individual.~~

(b) An entity shall not initiate a background study on any individual identified in paragraph (a), clauses (1) to ~~(5)~~ (3), if the individual has a valid license issued by a health-related licensing board as defined in section 214.01, subdivision 2, and has completed the criminal background check as required in section 214.075. An entity that is affiliated with individuals who meet the requirements of this paragraph must separate those individuals from the entity's roster for NETStudy 2.0. The Department of Human Services is not liable for conducting background studies that have been submitted or not removed from the roster in violation of this provision.

~~(c) If a facility or program is licensed by the Department of Human Services and the Department of Health and is subject to the background study provisions of this chapter, the~~

~~Department of Human Services is solely responsible for the background studies of individuals in the jointly licensed program.~~

~~(d) The commissioner of health shall review and make decisions regarding reconsideration requests, including whether to grant variances, according to the procedures and criteria in this chapter. The commissioner of health shall inform the requesting individual and the Department of Human Services of the commissioner of health's decision regarding the reconsideration. The commissioner of health's decision to grant or deny a reconsideration of a disqualification is a final administrative agency action.~~

Sec. 15. Minnesota Statutes 2024, section 245C.03, subdivision 5b, is amended to read:

Subd. 5b. **Facilities serving children or youth licensed by the Department of Corrections.** (a) The commissioner shall conduct background studies of ~~individuals~~ any individual with at least a five percent ownership stake in, an operator of, or an employee working in secure and nonsecure children's residential facilities, juvenile detention facilities, and foster residence settings, whether or not the individual will have direct contact, as defined under section 245C.02, subdivision 11, with persons served in the facilities or settings.

~~(b) A clerk or administrator of any court, the Bureau of Criminal Apprehension, a prosecuting attorney, a county sheriff, or a chief of a local police department shall assist in conducting background studies by providing the commissioner of human services or the commissioner's representative all criminal conviction data available from local and state criminal history record repositories related to applicants, operators, all persons living in a household, and all staff of any facility subject to background studies under this subdivision.~~

~~(c)~~ (b) For the purpose of this subdivision, the term "secure and nonsecure residential facility and detention facility" includes programs licensed or certified under section 241.021, subdivision 2.

~~(d) If an individual is disqualified, the Department of Human Services shall notify the disqualified individual and the facility in which the disqualified individual provides services of the disqualification and shall inform the disqualified individual of the right to request a reconsideration of the disqualification by submitting the request to the Department of Corrections.~~

~~(e) The commissioner of corrections shall review and make decisions regarding reconsideration requests, including whether to grant variances, according to the procedures and criteria in this chapter. The commissioner of corrections shall inform the requesting~~

~~individual and the Department of Human Services of the commissioner of corrections' decision regarding the reconsideration. The commissioner of corrections' decision to grant or deny a reconsideration of a disqualification is the final administrative agency action.~~

Sec. 16. Minnesota Statutes 2024, section 245C.03, subdivision 7, is amended to read:

Subd. 7. **Children's therapeutic services and supports providers.** The commissioner shall conduct background studies of ~~all direct service providers and volunteers~~ any individual with at least a five percent ownership stake in, an operator of, or an employee or volunteer for children's therapeutic services and supports providers under section 256B.0943.

Sec. 17. Minnesota Statutes 2024, section 245C.03, subdivision 9, is amended to read:

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

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

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

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

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

~~(3) a background study must be initiated and completed for all support workers.~~

The commissioner shall conduct background studies of any individual with at least a five percent ownership stake in, an operator of, or an employee or volunteer for Community First Services and Supports (CFSS) agency-providers and Financial Management Services providers enrolled to provide CFSS services under section 256B.85. For the purposes of

this subdivision, operator includes board members or other individuals who oversee the billing, management, or policies of the services provided.

Sec. 18. Minnesota Statutes 2024, section 245C.03, subdivision 10, is amended to read:

Subd. 10. **Providers of housing support or supplementary services.** ~~(a)~~ The commissioner shall conduct background studies of the following individuals who provide services under section 256I.04:

(1) controlling individuals as defined in section 245A.02;

(2) managerial officials as defined in section 245A.02; and

(3) all employees and volunteers of the establishment who have direct contact with recipients or who have unsupervised access to recipients, recipients' personal property, or recipients' private data.

~~(b) The provider of housing support must comply with all requirements for entities initiating background studies under this chapter.~~

~~(c) A provider of housing support must demonstrate that all individuals who are required to have a background study according to paragraph (a) have a notice stating that:~~

~~(1) the individual is not disqualified under section 245C.14; or~~

~~(2) the individual is disqualified and the individual has been issued a set aside of the disqualification for the setting under section 245C.22.~~

Sec. 19. Minnesota Statutes 2024, section 245C.03, subdivision 12, is amended to read:

Subd. 12. **Providers of special transportation service.** ~~(a)~~ The commissioner shall conduct background studies of the following individuals who provide special transportation services under section 174.30:

(1) each person with a direct or indirect ownership interest of five percent or higher in a transportation service provider;

(2) each controlling individual as defined under section 245A.02;

(3) a managerial official as defined in section 245A.02;

(4) each driver employed by the transportation service provider;

(5) each individual employed by the transportation service provider to assist a passenger during transport; and

(6) each employee of the transportation service agency who provides administrative support, including an employee who:

(i) may have face-to-face contact with or access to passengers, passengers' personal property, or passengers' private data;

(ii) performs any scheduling or dispatching tasks; or

(iii) performs any billing activities.

~~(b) When a local or contracted agency is authorizing a ride under section 256B.0625, subdivision 17, by a volunteer driver, and the agency authorizing the ride has a reason to believe that the volunteer driver has a history that would disqualify the volunteer driver or that may pose a risk to the health or safety of passengers, the agency may initiate a background study that shall be completed according to this chapter using the commissioner of human services' online NETStudy system, or by contacting the Department of Human Services background study division for assistance. The agency that initiates the background study under this paragraph shall be responsible for providing the volunteer driver with the privacy notice required by section 245C.05, subdivision 2c, and with the payment for the background study required by section 245C.10 before the background study is completed.~~

Sec. 20. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to read:

Subd. 17. **Providers of adult rehabilitative mental health services.** The commissioner shall conduct background studies on any individual with an ownership stake of at least five percent in an adult rehabilitative mental health services provider, an operator of an adult rehabilitative mental health services provider, or an employee or volunteer who has direct contact with people receiving adult rehabilitative mental health services under section 256B.0623.

Sec. 21. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to read:

Subd. 18. **Providers of peer recovery services.** The commissioner shall conduct background studies on any individual with an ownership stake of at least five percent in a peer recovery services provider, an operator of a peer recovery service provider, or an employee or volunteer who has direct contact with people receiving peer recovery services under section 254B.052.

Sec. 22. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to read:

Subd. 19. **Providers of adult assertive community treatment services.** The commissioner shall conduct background studies on any individual with an ownership stake of at least five percent in an adult assertive community treatment services provider, an operator of an adult assertive community treatment services provider, or an employee or volunteer who has direct contact with people receiving adult assertive community treatment services under section 256B.0622.

Sec. 23. Minnesota Statutes 2024, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. ~~**Licensed programs; other child care programs**~~ **When studies are initiated.** ~~(a) The commissioner shall conduct a background study of an individual required to be studied~~ For all studies required under section 245C.03~~, subdivision 1~~, the entity shall initiate the study using the electronic system known as NETStudy 2.0 at least upon application ~~for initial license for all license types~~ or enrollment and before owning, operating, or providing direct contact services.

~~(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, including a child care background study subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed child care center, certified license-exempt child care center, or legal nonlicensed child care provider, on a schedule determined by the commissioner. Except as provided in section 245C.05, subdivision 5a, a child care background study must include submission of fingerprints for a national criminal history record check and a review of the information under section 245C.08. A background study for a child care program must be repeated within five years from the most recent study conducted under this paragraph.~~

~~(c) At reauthorization or when a new background study is needed under section 142E.16, subdivision 2, for a legal nonlicensed child care provider authorized under chapter 142E:~~

~~(1) for a background study affiliated with a legal nonlicensed child care provider, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the commissioner and be fingerprinted and photographed under section 245C.05, subdivision 5; and~~

~~(2) the commissioner shall verify the information received under clause (1) and submit the request in NETStudy 2.0 to complete the background study.~~

~~(d) At reapplication for a family child care license:~~

~~(1) for a background study affiliated with a licensed family child care center, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be fingerprinted and photographed under section 245C.05, subdivision 5;~~

~~(2) the county agency shall verify the information received under clause (1) and forward the information to the commissioner and submit the request in NETStudy 2.0 to complete the background study; and~~

~~(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08.~~

~~(e) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:~~

~~(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;~~

~~(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and~~

~~(3) the last study of the individual was conducted on or after October 1, 1995.~~

~~(f) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with a child foster family setting license holder:~~

~~(1) the county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5, when the child foster family setting applicant or license holder resides in the home where child foster care services are provided; and~~

~~(2) the background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.~~

~~(g) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated with an adult foster care or family adult day services and with a family child care license holder or a legal nonlicensed child care provider authorized under chapter 142E and:~~

~~(1) except as provided in section 245C.05, subdivision 5a, the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraph (b), for background studies conducted by the commissioner for all family adult day services, for adult foster care when the adult foster care license holder resides in the adult foster care residence, and for family child care and legal nonlicensed child care authorized under chapter 142E;~~

~~(2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and~~

~~(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.~~

~~(h) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study requests to the commissioner using the electronic system known as NETStudy before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.~~

~~(i) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy when:~~

~~(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or~~

~~(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.~~

~~The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.~~

~~(j) For purposes of this section, a physician licensed under chapter 147, advanced practice registered nurse licensed under chapter 148, or physician assistant licensed under chapter 147A is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's, advanced practice registered nurse's, or physician assistant's background study results.~~

~~(k) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.~~

~~(l) A repeat background study at the time of license renewal is not required if the family child care substitute caregiver's background study was completed by the commissioner on or after October 1, 2017, and the substitute caregiver is on the license holder's active roster in NETStudy 2.0.~~

~~(m) Before and after school programs authorized under chapter 142E, are exempt from the background study requirements under section 123B.03, for an employee for whom a background study under this chapter has been completed.~~

Sec. 24. Minnesota Statutes 2024, section 245C.04, subdivision 4a, is amended to read:

Subd. 4a. **Agency background studies; electronic criminal case information updates; rosters; and criteria for eliminating repeat background studies.** (a) ~~The commissioner shall develop and implement an electronic process as a part of NETStudy 2.0 for the regular transfer of new criminal case information that is added to the Minnesota court information system. The commissioner's system must include for review only information that relates to individuals who are on the master roster.~~ Entities initiating studies under section 245C.03 are exempt from any requirement to initiate repeat studies as long as the individual remains continually affiliated with the roster; the individual has a final determination of eligibility, a set aside, or a variance granted; and the individual's legal name does not change.

(b) ~~The commissioner shall develop and implement an online system as a part of NETStudy 2.0 for agencies that initiate background studies under this chapter to access and maintain records of background studies initiated by that agency. The system must show all active background study subjects affiliated with that agency and the status of each individual's background study. Each agency that initiates background studies must use this system to notify the commissioner of discontinued affiliation for purposes of the processes required under paragraph (a).~~ Notwithstanding paragraph (a), every individual continuously affiliated with a child care provider must have a new background study initiated every five years.

~~(c) After an entity initiating a background study has paid the applicable fee for the study and has provided the individual with the privacy notice required under section 245C.05, subdivision 2c, NETStudy 2.0 shall immediately inform the entity whether the individual requires a background study or whether the individual is immediately eligible to provide services based on a previous background study. If the individual is immediately eligible, the entity initiating the background study shall be able to view the information previously supplied by the individual who is the subject of a background study as required under section~~

~~245C.05, subdivision 1, including the individual's photograph taken at the time the individual's fingerprints were recorded. The commissioner shall not provide any entity initiating a subsequent background study with information regarding the other entities that initiated background studies on the subject.~~

~~(d) Verification that an individual is eligible to provide services based on a previous background study is dependent on the individual voluntarily providing the individual's Social Security number to the commissioner at the time each background study is initiated. When an individual does not provide the individual's Social Security number for the background study, that study is not transferable and a repeat background study on that individual is required if the individual seeks a position requiring a background study under this chapter with another entity.~~

Sec. 25. Minnesota Statutes 2025 Supplement, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph (c), for background studies conducted by the commissioner for current or prospective child foster or adoptive parents, and for any adult working in a children's residential facility, the subject of the background study shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency for a national criminal history record check.

(b) Notwithstanding paragraph (c), for background studies conducted by the commissioner for Head Start programs, the subject of the background study shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency for a national criminal history record check.

(c) For background studies initiated on or after the implementation of NETStudy 2.0, except as provided under subdivision 5a, every subject of a background study must provide the commissioner with a set of the background study subject's classifiable fingerprints and photograph. The photograph and fingerprints must be recorded at the same time by the authorized fingerprint collection vendor or vendors and sent to the commissioner through the commissioner's secure data system described in section 245C.32, subdivision 1a, paragraph (b).

(d) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal Apprehension and, when specifically required by law, submitted to the Federal Bureau of Investigation for a national criminal history record check.

(e) The fingerprints must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints.

(f) The authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the name and date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities.

(g) For any background study conducted under this chapter, except for family child foster care ~~or~~, adoption, adult day services, or adult foster care studies, the subject shall provide the commissioner with a set of classifiable fingerprints when the commissioner has reasonable cause to require a national criminal history record check as defined in section 245C.02, subdivision 15a.

EFFECTIVE DATE. This section is effective January 25, 2028.

Sec. 26. Minnesota Statutes 2025 Supplement, section 245C.05, subdivision 5a, is amended to read:

Subd. 5a. **Background study requirements for minors.** (a) A background study completed under this chapter on a subject who is required to be studied under section 245C.03~~, subdivision 1,~~ and is 17 years of age or younger shall be completed by the commissioner for:

(1) a legal nonlicensed child care provider authorized under chapter 142E;

(2) a licensed family child care program; or

(3) a licensed foster care home.

(b) The subject shall submit to the commissioner only the information under subdivision 1, paragraph (a).

(c) For child care studies, a subject who is 17 years of age or younger is required to submit fingerprints and a photograph, and the commissioner shall conduct a national criminal history record check, if:

(1) the commissioner has reasonable cause to require a national criminal history record check defined in section 245C.02, subdivision 15a; or

(2) under paragraph (a), clauses (1) and (2), the subject is employed by the provider or supervises children served by the program.

(d) For child care studies, a subject who is 17 years of age or younger is required to submit non-fingerprint-based data according to section 245C.08, subdivision 1, paragraph (a), clause (6), item (iii), and the commissioner shall conduct the check if:

(1) the commissioner has reasonable cause to require a national criminal history record check defined in section 245C.02, subdivision 15a; or

(2) the subject is employed by the provider or supervises children served by the program under paragraph (a), clauses (1) and (2).

Sec. 27. Minnesota Statutes 2025 Supplement, section 245C.08, subdivision 1, is amended to read:

Subdivision 1. **Background studies conducted by Department of Human Services.** (a) For a background study conducted by the Department of Human Services, the commissioner shall review:

(1) information related to names of substantiated perpetrators of maltreatment of vulnerable adults that has been received by the commissioner as required under section 626.557, subdivision 9c, paragraph (j);

(2) the commissioner's records relating to the maltreatment of minors in licensed programs, and from findings of maltreatment of minors as indicated through the social service information system;

(3) information from juvenile courts as required for studies under this chapter when there is reasonable cause;

(4) information from the Bureau of Criminal Apprehension, including information regarding a background study subject's registration in Minnesota as a predatory offender under section 243.166;

(5) except as provided in clause (6), information received as a result of submission of fingerprints for a national criminal history record check, as defined in section 245C.02, subdivision 13c, when the commissioner has reasonable cause for a national criminal history record check as defined under section 245C.02, subdivision 15a, or as required under section 144.057, subdivision 1, clause (2);

(6) for a background study related to a child foster family setting application for licensure, foster residence settings, children's residential facilities, a transfer of permanent legal and

physical custody of a child under sections 260C.503 to 260C.515, or adoptions, and for a background study required for family child care, certified license-exempt child care, child care centers, and legal nonlicensed child care authorized under chapter 142E, the commissioner shall also review:

(i) information from the child abuse and neglect registry for any state in which the background study subject has resided for the past five years;

(ii) information received from a national criminal history record check, if authorized for the study; and

(iii) when the background study subject is 18 years of age or older or a minor under section 245C.05, subdivision 5a, paragraph (d), for licensed family child care, certified license-exempt child care, licensed child care centers, and legal nonlicensed child care authorized under chapter 142E, information obtained using non-fingerprint-based data including information from the criminal and sex offender registries for any state in which the background study subject resided for the past five years and information from the national crime information database and the national sex offender registry;

(7) for a background study required for family child care, certified license-exempt child care centers, licensed child care centers, and legal nonlicensed child care authorized under chapter 142E, the background study shall also include, to the extent practicable, a name and date-of-birth search of the National Sex Offender Public website; and

(8) for a background study required for treatment programs for sexual psychopathic personalities or sexually dangerous persons, the background study shall only include a review of the information required under paragraph (a), clauses (1) to (4).

(b) Except as otherwise provided in this paragraph, notwithstanding expungement by a court, the commissioner may consider information obtained under paragraph (a), clauses (3) and (4), unless:

(1) the commissioner received notice of the petition for expungement and the court order for expungement is directed specifically to the commissioner; or

(2) the commissioner received notice of the expungement order issued pursuant to section 609A.017, 609A.025, or 609A.035, and the order for expungement is directed specifically to the commissioner.

The commissioner may not consider information obtained under paragraph (a), clauses (3) and (4), or from any other source that identifies a violation of chapter 152 without determining if the offense involved the possession of marijuana or tetrahydrocannabinol

and, if so, whether the person received a grant of expungement or order of expungement, or the person was resentenced to a lesser offense. If the person received a grant of expungement or order of expungement, the commissioner may not consider information related to that violation but may consider any other relevant information arising out of the same incident.

(c) The commissioner shall also review criminal case information received according to section 245C.04~~, subdivision 4a,~~ from the Minnesota court information system that relates to individuals who have already been studied under this chapter and who remain affiliated with the agency that initiated the background study.

(d) When the commissioner has reasonable cause to believe that the identity of a background study subject is uncertain, the commissioner may require the subject to provide a set of classifiable fingerprints for purposes of completing a fingerprint-based record check with the Bureau of Criminal Apprehension. Fingerprints collected under this paragraph shall not be saved by the commissioner after they have been used to verify the identity of the background study subject against the particular criminal record in question.

(e) The commissioner may inform the entity that initiated a background study under NETStudy 2.0 of the status of processing of the subject's fingerprints.

Sec. 28. Minnesota Statutes 2024, section 245C.10, subdivision 4, is amended to read:

Subd. 4. **Temporary personnel agencies, personnel pool agencies, educational programs, and professional services agencies.** The commissioner shall recover the cost of the background studies initiated by temporary personnel agencies, personnel pool agencies, educational programs, and professional services agencies that initiate background studies under section 245C.03~~, subdivision 4,~~ through a fee of no more than $44 per study charged to the agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 29. Minnesota Statutes 2024, section 245C.10, subdivision 5, is amended to read:

Subd. 5. **Adult foster care and family adult day services.** The commissioner shall recover the cost of background studies required under section 245C.03~~, subdivision 1,~~ for the purposes of adult foster care and family adult day services licensing, through a fee of no more than $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 30. Minnesota Statutes 2024, section 245C.10, subdivision 8, is amended to read:

Subd. 8. **Children's therapeutic services and supports providers.** The commissioner shall recover the cost of background studies required under section 245C.03~~, subdivision 7,~~ for the purposes of children's therapeutic services and supports under section 256B.0943, through a fee of no more than $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 31. Minnesota Statutes 2025 Supplement, section 245C.10, subdivision 9, is amended to read:

Subd. 9. **Human services licensed programs.** The commissioner shall recover the cost of background studies required under section 245C.03~~, subdivision 1,~~ for all programs that are licensed by the commissioner through a fee of no more than $44 per study charged to the license holder. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 32. Minnesota Statutes 2024, section 245C.10, subdivision 17, is amended to read:

Subd. 17. **Early intensive developmental and behavioral intervention providers.** The commissioner shall recover the cost of background studies required under section 245C.03~~,~~ ~~subdivision 15,~~ for the purposes of early intensive developmental and behavioral intervention under section 256B.0949, through a fee of no more than $44 per study charged to the enrolled agency. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 33. Minnesota Statutes 2025 Supplement, section 245C.10, subdivision 22, is amended to read:

Subd. 22. **Recuperative care providers.** The commissioner shall recover the cost of background studies required under section 245C.03~~, subdivision 16,~~ for recuperative care under section 256B.0701, through a fee of no more than $44 per study charged to the enrolled provider. The fees collected under this subdivision are appropriated to the commissioner for the purpose of conducting background studies.

Sec. 34. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended to read:

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

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

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

(i) the individual is not disqualified; or

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

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

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

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

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

(1) being issued a license;

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

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

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

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

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

(7) for background studies affiliated with a personal care provider organization, ~~except as provided in section 245C.03, subdivision 3b,~~ early intensive developmental and behavioral intervention provider, housing support or supplementary services provider, special transportation services provider, or community first services and supports provider before ~~a personal care assistant~~ an individual provides services, the ~~personal care assistance provider agency~~ entity must initiate a background study of the ~~personal care assistant~~ individual under this chapter and the ~~personal care assistance provider agency~~ entity must have received a notice from the commissioner that the ~~personal care assistant~~ individual is:

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

(ii) disqualified, but the ~~personal care assistant~~ individual has received a set aside of the disqualification under section 245C.22~~; or~~.

~~(8) for background studies affiliated with an early intensive developmental and behavioral intervention provider, before an individual provides services, the early intensive developmental and behavioral intervention provider must initiate a background study for the individual under this chapter and the early intensive developmental and behavioral intervention provider must have received a notice from the commissioner that the individual is:~~

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

~~(ii) disqualified, but the individual has received a set-aside of the disqualification under section 245C.22.~~

Sec. 35. Minnesota Statutes 2024, section 245C.14, subdivision 1, is amended to read:

Subdivision 1. **Disqualification from direct contact.** (a) The commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in

section 245C.03, upon receipt of information showing, or when a background study completed under this chapter shows any of the following:

(1) a conviction of, admission to, or Alford plea to one or more crimes listed in section 245C.15, regardless of whether the conviction or admission is a felony, gross misdemeanor, or misdemeanor level crime;

(2) a preponderance of the evidence indicates the individual has committed an act or acts that meet the definition of any of the crimes listed in section 245C.15, regardless of whether the preponderance of the evidence is for a felony, gross misdemeanor, or misdemeanor level crime;

(3) an investigation results in an administrative determination listed under section 245C.15, subdivision 4, paragraph (b); or

(4) the individual's parental rights have been terminated under section 260C.301, subdivision 1, paragraph (b), or section 260C.301, subdivision 3.

(b) No individual who is disqualified following a background study under section 245C.03~~, subdivisions 1 and 2,~~ may be retained in a position involving direct contact with persons served by a program or entity identified in section 245C.03, unless the commissioner has provided written notice under section 245C.17 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245C.21, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that program or entity identified in section 245C.03, as provided in section 245C.22, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245C.30.

(c) Notwithstanding paragraph (a), for the purposes of a background study affiliated with a licensed family foster setting, the commissioner shall disqualify an individual who is the subject of a background study from any position allowing direct contact with persons receiving services from the license holder or entity identified in section 245C.03, upon receipt of information showing or when a background study completed under this chapter shows reason for disqualification under section 245C.15, subdivision 4a.

Sec. 36. Minnesota Statutes 2024, section 245C.14, subdivision 2, is amended to read:

Subd. 2. **Disqualification from access.** (a) If an individual who is studied under section 245C.03~~, subdivision 1, paragraph (a), clauses (2), (5), and (6),~~ is disqualified from direct

contact under subdivision 1, the commissioner shall also disqualify the individual from access to a person receiving services from the license holder.

(b) No individual who is disqualified following a background study under section 245C.03~~, subdivision 1, paragraph (a), clauses (2), (5), and (6), or as provided elsewhere in statute who is disqualified as a result of this section,~~ may be allowed access to persons served by the program unless the commissioner has provided written notice under section 245C.17 stating that:

(1) the individual may remain in direct contact during the period in which the individual may request reconsideration as provided in section 245C.21, subdivision 2;

(2) the commissioner has set aside the individual's disqualification for that licensed program or entity identified in section 245C.03 as provided in section 245C.22, subdivision 4; or

(3) the license holder has been granted a variance for the disqualified individual under section 245C.30.

Sec. 37. Minnesota Statutes 2025 Supplement, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside;

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program and from working in a children's residential facility or foster residence setting; and

(9) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 2, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense during the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with or access to persons receiving services from the center and from working in a licensed child care center or certified license-exempt child care center.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

(d) This section does not apply to a background study related to an initial application for a child foster family setting license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section ~~256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1, or to a background study for an individual providing early intensive developmental and behavioral intervention services under section 256B.0949~~ 245C.13, subdivision 2, paragraph (c), clause (7).

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

Sec. 38. Minnesota Statutes 2025 Supplement, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23. For personal care provider organizations, financial management services organizations, community first services and supports organizations, unlicensed home and community-based organizations, and consumer-directed community supports organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04~~, subdivision 1, paragraph (h),~~ if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the substance use disorder field, if the commissioner has previously set aside an individual's disqualification for one or more programs or agencies in the substance use disorder treatment field, and the individual is the subject of a subsequent background study for a different

program or agency in the substance use disorder treatment field, the commissioner shall set aside the disqualification for the program or agency in the substance use disorder treatment field that initiated the subsequent background study when the criteria under paragraph (b), clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified in section 245C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued within 15 working days.

(d) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

Sec. 39. Minnesota Statutes 2024, section 245C.24, subdivision 2, is amended to read:

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in paragraphs (b) to (g), the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual in the substance use disorder or corrections field who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification was set aside prior to July 1, 2005, the commissioner must consider granting a variance pursuant to section 245C.30 for the license holder for a program dealing primarily with adults. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set-aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service.

(c) If an individual who requires a background study for nonemergency medical transportation services under section 245C.03~~, subdivision 12,~~ was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have passed since the discharge of the sentence imposed, the commissioner may consider granting a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the employer. This paragraph does not apply to a person disqualified based on a violation of sections 243.166; 609.185 to

609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3, clause (1); 617.246; or 617.247.

(d) When a licensed foster care provider adopts an individual who had received foster care services from the provider for over six months, and the adopted individual is required to receive a background study under section 245C.03~~, subdivision 1, paragraph (a), clause (2) or (6)~~, the commissioner may grant a variance to the license holder under section 245C.30 to permit the adopted individual with a permanent disqualification to remain affiliated with the license holder under the conditions of the variance when the variance is recommended by the county of responsibility for each of the remaining individuals in placement in the home and the licensing agency for the home.

(e) For an individual 18 years of age or older affiliated with a licensed family foster setting, the commissioner must not set aside or grant a variance for the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraphs (a) and (b).

(f) In connection with a family foster setting license, the commissioner may grant a variance to the disqualification for an individual who is under 18 years of age at the time the background study is submitted.

(g) In connection with foster residence settings and children's residential facilities, the commissioner must not set aside or grant a variance for the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraph (a) or (b).

Sec. 40. Minnesota Statutes 2024, section 245D.09, subdivision 6, is amended to read:

Subd. 6. **Subcontractors and temporary staff.** If the license holder uses a subcontractor or temporary staff to perform services licensed under this chapter on the license holder's behalf, the license holder must ensure that the subcontractor or temporary staff meets and maintains compliance with all requirements under this chapter that apply to the services to be provided, including training, orientation, and supervision necessary to fulfill their responsibilities. The license holder must ensure that a background study has been completed according to the requirements in sections 245C.03~~, subdivision 1,~~ and 245C.04. Subcontractors and temporary staff hired by the license holder must meet the Minnesota licensing requirements applicable to the disciplines in which they are providing services.

The license holder must maintain documentation that the applicable requirements have been met.

Sec. 41. Minnesota Statutes 2024, section 245D.09, subdivision 7, is amended to read:

Subd. 7. **Volunteers.** The license holder must ensure that volunteers who provide direct support services to persons served by the program receive the training, orientation, and supervision necessary to fulfill their responsibilities. The license holder must ensure that a background study has been completed according to the requirements in sections 245C.03~~, subdivision 1,~~ and 245C.04. The license holder must maintain documentation that the applicable requirements have been met.

Sec. 42. Minnesota Statutes 2024, section 256B.0943, subdivision 5a, is amended to read:

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.

Sec. 43. Minnesota Statutes 2025 Supplement, section 256I.04, subdivision 2c, is amended to read:

Subd. 2c. **Background study requirements.** (a) A provider of housing support must initiate background studies in accordance with section 245C.03~~, subdivision 10~~.

(b) A provider initiating a background study pursuant to chapter 245C is not required to initiate a background study in accordance with sections 299C.66 to 299C.71 or chapter 364.

Sec. 44. **REPEALER.**

(a) Minnesota Statutes 2024, sections 245C.03, subdivisions 3a, 3b, 5, 6a, and 9a; and 245C.04, subdivisions 2, 3, 4, 5, 7, 8, 9, 10, and 11, are repealed.

(b) Minnesota Statutes 2025 Supplement, section 245C.04, subdivisions 6, 12, and 13, are repealed.

ARTICLE 7
MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 62D.04, subdivision 5, is amended to read:

Subd. 5. **Participation; government programs.** (a) Health maintenance organizations that are a nonprofit corporation organized under chapter 317A or a local governmental unit shall, as a condition of receiving and retaining a certificate of authority, participate in the medical assistance and MinnesotaCare programs. A health maintenance organization governed by this subdivision is required to submit proposals in good faith that meet the requirements of the request for proposal provided that the requirements can be reasonably met by a health maintenance organization to serve individuals eligible for the above programs in a geographic region of the state if, at the time of publication of a request for proposal, the percentage of recipients in the public programs in the region who are enrolled in the health maintenance organization is less than the health maintenance organization's percentage of the total number of individuals enrolled in health maintenance organizations in the same region. Geographic regions shall be defined by the commissioner of human services in the request for proposals. This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2029, or upon the date the administrative service organization begins administering medical assistance under section 256B.697, whichever is later, a health maintenance organization that is a nonprofit corporation organized under chapter 317A or a local governmental unit shall, as a condition of receiving and retaining a certificate of authority, participate in the integrated medical assistance and MinnesotaCare programs. A health maintenance organization governed by this subdivision is required to submit proposals in good faith that meet the requirements of the request for proposal provided that the requirements can be reasonably met by a health maintenance organization. A health maintenance organization must serve individuals eligible for the integrated medical assistance and MinnesotaCare programs in a geographic region of the state if, at the time of publication of a request for proposal, the percentage of recipients in the public programs in the region who are enrolled in the health maintenance organization is less than the health maintenance organization's percentage of the total number of individuals enrolled in health maintenance organizations in the same region. The commissioner of human services must define geographic regions in the request for proposals.

(c) The commissioner of human services must notify the revisor of statutes when the administrative service organization begins administering medical assistance.

Sec. 2. Minnesota Statutes 2024, section 256B.05, subdivision 1, is amended to read:

Subdivision 1. **Administration of medical assistance.** (a) The county agencies shall administer medical assistance in their respective counties under the supervision of the state agency and the commissioner of human services as specified in section 256.01, and shall make such reports, prepare such statistics, and keep such records and accounts in relation to medical assistance as the state agency may require under section 256.01, subdivision 2, paragraph (o).

(b) The commissioner must administer specific duties related to determining medical assistance eligibility on behalf of a county agency administration to ensure compliance with federal and state requirements for the medical assistance program. The commissioner must undertake the specific duties on a statewide and uniform administrative and operational basis.

Sec. 3. Minnesota Statutes 2024, section 256B.0625, subdivision 3c, is amended to read:

Subd. 3c. **Health Services Advisory Council.** (a) The commissioner, after receiving recommendations from professional physician associations, professional associations representing licensed nonphysician health care professionals, and consumer groups, shall establish a 14-member Health Services Advisory Council, which consists of 13 voting members and one nonvoting member. The Health Services Advisory Council shall advise the commissioner regarding (1) health services pertaining to the administration of health care benefits covered under Minnesota health care programs (MHCP); and (2) evidence-based decision-making and health care benefit and coverage policies for MHCP. The Health Services Advisory Council shall consider available evidence regarding quality, safety, and cost-effectiveness when advising the commissioner. The Health Services Advisory Council shall meet at least quarterly. The Health Services Advisory Council shall annually select a chair from among its members who shall work directly with the commissioner's medical director to establish the agenda for each meeting. The Health Services Advisory Council may recommend criteria for verifying centers of excellence for specific aspects of medical care where a specific set of combined services, a volume of patients necessary to maintain a high level of competency, or a specific level of technical capacity is associated with improved health outcomes.

(b) The commissioner shall establish a dental subcouncil to operate under the Health Services Advisory Council. The dental subcouncil consists of general dentists, dental specialists, safety net providers, dental hygienists, ~~health plan company~~ entities under contract to serve MHCP and county and public health representatives, health researchers,

consumers, and a designee of the commissioner of health. The dental subcouncil shall advise the commissioner regarding:

(1) the critical access dental program under section 256B.76, subdivision 4, including but not limited to criteria for designating and terminating critical access dental providers;

(2) any changes to the critical access dental provider program necessary to comply with program expenditure limits;

(3) dental coverage policy based on evidence, quality, continuity of care, and best practices;

(4) the development of dental delivery models; and

(5) dental services to be added or eliminated from subdivision 9.

(c) The Health Services Advisory Council may monitor and track the practice patterns of health care providers who serve MHCP recipients ~~under fee-for-service, managed care, and county-based purchasing~~. The monitoring and tracking shall focus on services or specialties for which there is a high variation in utilization or quality across providers, or which are associated with high medical costs. The commissioner, based upon the findings of the Health Services Advisory Council, may notify providers whose practice patterns indicate below average quality or higher than average utilization or costs. ~~Managed care and county-based purchasing plans~~ Entities contracted to administer MHCP programs shall provide the commissioner with utilization and cost data necessary to implement this paragraph, and the commissioner shall make these data available to the Health Services Advisory Council.

Sec. 4. Minnesota Statutes 2024, section 256B.0625, subdivision 3d, is amended to read:

Subd. 3d. **Health Services Advisory Council members.** (a) The Health Services Advisory Council consists of:

(1) six voting members who are licensed physicians actively engaged in the practice of medicine in Minnesota, three of whom must represent ~~health plans~~ entities currently under contract to serve MHCP recipients, including but not limited to integrated health partnerships, health plans, and county-based purchasing plans;

(2) two voting members who are licensed physician specialists actively practicing their specialty in Minnesota and providing care to MHCP recipients;

(3) two voting members who are nonphysician health care professionals licensed or registered in their profession and actively engaged in their practice of their profession in Minnesota and providing care to MHCP recipients;

(4) one voting member who is a health care or mental health professional licensed or registered in the member's profession, actively engaged in the practice of the member's profession in Minnesota, ~~and~~ actively engaged in the treatment of persons with mental illness, and providing care to MHCP recipients;

(5) two consumers who are enrolled in MHCP programs directly or are caregivers for MHCP recipients who shall serve as voting members; and

(6) the commissioner's medical director who shall serve as a nonvoting member.

(b) Members of the Health Services Advisory Council shall not be employed by the state of Minnesota, except for the medical director. A quorum shall comprise a simple majority of the voting members. Vacant seats shall not count toward a quorum.

Sec. 5. Minnesota Statutes 2025 Supplement, section 256B.0911, subdivision 14, is amended to read:

Subd. 14. **Use of MnCHOICES certified assessors required.** (a) Each lead agency shall use MnCHOICES certified assessors who have completed MnCHOICES training and the certification process determined by the commissioner in subdivision 13.

(b) Each lead agency must ensure that the lead agency has sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service.

(c) A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) A lead agency must provide the commissioner with an administrative contact for communication purposes.

(f) A lead agency may contract under this subdivision with any hospital licensed under sections 144.50 to 144.56 to conduct assessments of patients in the hospital on behalf of the lead agency when the lead agency has failed to meet its obligations under subdivision 17. The contracted assessment must be conducted by a hospital employee who is a qualified,

certified assessor. The hospital employees who perform assessments under the contract between the hospital and the lead agency may perform assessments in addition to other duties assigned to the employee by the hospital, except the hospital employees who perform the assessments under contract with the lead agency must not perform any waiver-related tasks other than assessments. Hospitals are not eligible for reimbursement under subdivision 33. The lead agency that enters into a contract with a hospital under this paragraph is responsible for oversight, compliance, and quality assurance for all assessments performed under the contract.

(g) The commissioner must employ certified assessors within the department to conduct assessments on behalf of lead agencies under conditions and circumstances determined by the commissioner. Certified assessors employed by the department may conduct assessments in addition to other duties as assigned, except the certified assessors employed by the department must not perform any responsibilities of a lead agency described in this section other than assessments. Nothing in this paragraph creates an obligation for the department to provide the department's certified assessors to conduct assessments on behalf of a lead agency.

Sec. 6. Minnesota Statutes 2024, section 256B.69, subdivision 1, is amended to read:

Subdivision 1. **Purpose.** (a) The commissioner of human services shall establish a medical assistance demonstration project to determine whether prepayment combined with better management of health care services is an effective mechanism to ensure that all eligible individuals receive necessary health care in a coordinated fashion while containing costs. For the purposes of this project, waiver of certain statutory provisions is necessary in accordance with this section.

(b) Effective January 1, 2029, or upon the date the administrative service organization begins administering medical assistance under section 256B.697, whichever is later, this section applies only to medical assistance members enrolled in integrated Medicare products for individuals with disabilities and seniors and MinnesotaCare. The commissioner of human services must notify the revisor of statutes when the administrative service organization begins administering medical assistance.

Sec. 7. **[256B.697] MEDICAL ASSISTANCE ADMINISTRATIVE SERVICE ORGANIZATION.**

(a) Effective January 1, 2029, the commissioner must contract with an administrative service organization to administer the medical assistance program on a statewide basis. The

administrator is responsible for the administration of all populations within medical assistance except individuals enrolled in integrated Medicare products, including but not limited to Minnesota Senior Health Options and Special Needs BasicCare.

(b) Services performed by the administrator may include but are not limited to:

(1) claims processing for all covered services;

(2) coordination of care for members;

(3) program integrity initiatives;

(4) management of third-party liability requirements;

(5) development, execution, and maintenance of a claims processing system compliant with all applicable state and federal laws and regulations;

(6) assistance and outreach to recipients to manage and access needed care;

(7) assistance and outreach to enrolled providers;

(8) utilization management and medical necessity review of services; and

(9) quality improvement and program evaluation initiatives.

(c) Rates paid to providers under this section must be the same rates paid to providers under this chapter and chapter 256.

(d) The administrator may, with the approval of the commissioner, elect to subcontract with other entities to assist in the delivery and administration of services.

(e) The commissioner may elect to contract separately from the administrative services organization for care coordination if the commissioner determines additional support is needed for members to access medically necessary care.

Sec. 8. **DIRECTION TO COMMISSIONER; ADMINISTRATIVE SERVICE ORGANIZATION TRANSFER ASSESSMENT.**

(a) The commissioner of human services must procure a contract with a vendor to assess the current status and plan for the transfer of administration of medical assistance to the commissioner's administrative service organization under Minnesota Statutes, section 256B.697, by January 1, 2033. The commissioner must submit the assessment to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and health care policy and finance by October 1, 2028.

(b) The assessment must include:

(1) a comprehensive assessment of medical assistance eligibility functions performed by counties and Tribal governments, including identification of handoffs between county and Tribal eligibility workers and state eligibility workers, and a catalog of eligibility functions performed by state eligibility workers;

(2) examination of current expenditures, administrative budgets, and federal financial participation in county and Tribal administrative work related to medical assistance eligibility activities;

(3) eligibility system review, mapping, and recommended updates; and

(4) recommendations for a successful transition of centralized eligibility functions based on consultation with stakeholders, review of information provided by county and Tribal governments, review of other states' best practices for maximizing federal dollars, a feasible timeline of activities, and required legislative changes and actions.

(c) The commissioner must consult with the Tribal Nations, the Association of Minnesota Counties, and the Minnesota Association of County Social Service Administrators on the final deliverables included in the assessment.

Sec. 9. **MNCHOICES REDESIGN WORKING GROUP.**

Subdivision 1. **Establishment.** The commissioner of human services shall convene a MnCHOICES Redesign Working Group to develop recommendations related to state provision of MnCHOICES assessments under Minnesota Statutes, section 256B.0911, subdivision 14, paragraph (g).

Subd. 2. **Membership.** At a minimum, the working group must include the following members:

(1) two individuals receiving waiver services or the individuals' family members or advocates, appointed by the commissioner in consultation with organizations representing individuals with lived experience of disability and waiver services;

(2) three county representatives, appointed by the Minnesota Association of County Social Service Administrators, including;

(i) at least one representative of a lead agency located in a metropolitan county, as defined in Minnesota Statutes, section 473.121, subdivision 4; and

(ii) at least two representatives of lead agencies located outside of a metropolitan county, as defined in Minnesota Statutes, section 473.121, subdivision 4;

(3) one staff member from the Minnesota Social Service Association, appointed by the Minnesota Social Service Association;

(4) at least three representatives from Tribal Nations, appointed by the commissioner;

(5) two representatives of disability advocacy organizations, appointed by the commissioner; and

(6) additional nonvoting participants as determined by the commissioner, which may include staff from the Department of Human Services and other interested parties.

Subd. 3. **Duties.** The working group shall make recommendations to shift the responsibility and administration of conducting MnCHOICES assessments to the state. Recommendations must include:

(1) defined roles and responsibilities between county, Tribal Nation, and state functions;

(2) revised payment methodologies and financing of duties;

(3) efficient workflows between local and state functions;

(4) service continuity for people seeking and receiving long-term services and supports; and

(5) methods for gathering public feedback and providing public awareness.

Subd. 4. **Terms, compensation, and removal.** The terms, compensation, and removal of the working group members are governed by Minnesota Statutes, section 15.059, subdivision 3.

Subd. 5. **Meetings; administrative support.** (a) The first meeting of the working group must be convened no later than August 1, 2026. The working group must meet at least monthly. The working group may meet by telephone or interactive technology consistent with Minnesota Statutes, section 13D.015.

(b) The Department of Human Services shall provide staff and administrative support to convene the working group, facilitate working group meetings, and prepare the final report.

Subd. 6. **Report.** By September 1, 2027, the commissioner must submit a report of the working group's findings and recommendations, including but not limited to any legislative changes necessary to implement the recommendations, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance.

Subd. 7. **Expiration.** The working group expires upon submission of the report required under subdivision 6.

Sec. 10. **DIRECTION TO COMMISSIONER; WAIVER CASE MANAGEMENT REQUIREMENTS AND COSTS STUDY.**

(a) The commissioner of human services must analyze and provide recommendations on waiver case management services. The commissioner must develop a request for proposals for a contract with a third party to conduct a study. The study and recommendations must include:

(1) definition of roles and responsibilities for waiver case management services, including but not limited to oversight functions and requirements of waiver case management services;

(2) an assessment of providing waiver case management in acute care settings to ensure continuity of care; and

(3) an update to the rate methodology to ensure payments reflect the costs of providing waiver case management services.

(b) The commissioner must consult with lead agencies, providers across the spectrum of services and regions of the state, and culturally responsive providers in the development of the request for proposals for the study and for the duration of the contract.

(c) By June 30, 2027, the commissioner must submit a final report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance that includes the results of the analysis and the recommendations required under this section.

Sec. 11. **DIRECTION TO COMMISSIONER; ASSESSMENT OF ADMINISTRATION ROLES.**

(a) The commissioner of human services, in consultation with Tribal Nations and counties, must conduct a study to assess and recommend improvements to the roles and responsibilities of the state agency, counties, and Tribal Nations in administering human services programs.

(b) The study must include a comprehensive review of programs administered by the department, including but not limited to medical assistance, MinnesotaCare, behavioral health services, long-term services and supports, housing and homelessness programs, Minnesota supplemental aid, general assistance, and licensing and oversight functions.

(c) The study must evaluate the:

(1) current roles and responsibilities held by the state agency, counties, and Tribal Nations in administering human services programs, including but not limited to the challenges and benefits of the current delegation of roles and responsibilities;

(2) lived experience of people accessing human services programs related to the delegation of administrative duties;

(3) financing of human services program administration across the state agency, counties, and Tribal Nations; and

(4) administration of human services programs in other states, focusing on the roles and responsibilities of the local governments versus the state Medicaid or human services agency, and identifying the benefits, challenges, and financing of the delegation of duties.

(d) The study must focus on the goals of transforming the human services system to ensure a transparent, accessible, accountable, equitable, and effective human services system.

(e) The study must provide recommendations for the optimal delegation of duties between the state agency, counties, and Tribal Nations in the delivery of human services. Recommendations must include:

(1) how the delegation of duties will improve the experience of people accessing human services;

(2) implementation and timing considerations to ensure continuity of services;

(3) systems technology adaptations required;

(4) workforce considerations; and

(5) financing strategies and the estimated fiscal impact to the state budget.

(f) By October 1, 2028, the commissioner must submit a report on the study and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 12. **REPEALER.**

(a) Minnesota Statutes 2024, section 256B.0371, subdivisions 1, 2, and 4, are repealed.

(b) Minnesota Statutes 2025 Supplement, sections 256B.0371, subdivision 3; and 256B.696, are repealed.

(c) Minnesota Statutes 2025 Supplement, section 256B.695, is repealed.

EFFECTIVE DATE. Paragraphs (a) and (b) are effective the day following final enactment. Paragraph (c) is effective January 1, 2029, or upon the date the administrative service organization begins administering medical assistance under Minnesota Statutes, section 256B.697, whichever is later. The commissioner of human services must notify the revisor of statutes when the administrative service organization begins administering medical assistance.

ARTICLE 8

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 3, article 20, 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.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	**$ -0-**	**$ (100,804,000)**

Subdivision 1. **Total Appropriation**

Appropriations by Fund	2026	2027
General	-0-	(102,817,000)
State Government Special Revenue	-0-	2,013,000

The amounts that may be spent for each purpose are specified in this article.

Sec. 3. **CENTRAL OFFICE; OPERATIONS**	**$ -0-**	**$ 29,507,000**

Subdivision 1. **Base Adjustment**

The general fund base for appropriations for this section is increased by $27,301,000 in fiscal year 2028 and $26,427,000 in fiscal year 2029.

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 programs. This is a onetime appropriation and is available until June 30, 2029.

Subd. 3. **Evaluation of DHS Structure and Processes**

$500,000 in fiscal year 2027 is for a comprehensive evaluation of DHS's structure and processes. This is a onetime appropriation and is available until June 30, 2028.

Subd. 4. **Waiver Case Management Study**

$300,000 in fiscal year 2027 is for a study on waiver case management services. This is a onetime appropriation and is available until June 30, 2028.

Sec. 4. **CENTRAL OFFICE; HEALTH CARE** **$** **-0-** **$** **49,727,000**

Subdivision 1. **Medical Assistance Eligibility Study**

$2,000,000 in fiscal year 2027 is for a study on the transfer of eligibility functions of the medical assistance program performed by county and Tribal governments to the Department of Human Services. This is a onetime appropriation and is available until June 30, 2029.

Subd. 2. **Base Adjustment**

The general fund base for appropriations in this section is increased by $86,547,000 in fiscal year 2028 and $102,390,000 in fiscal year 2029.

Sec. 5. **CENTRAL OFFICE; AGING AND DISABILITY SERVICES** **$** **-0-** **$** **3,385,000**

The general fund base for appropriations in this section is increased by $10,070,000 in fiscal year 2028 and $9,427,000 in fiscal year 2029.

Sec. 6. **CENTRAL OFFICE; BEHAVIORAL HEALTH** **$** **-0-** **$** **538,000**

Subdivision 1. **Base Adjustment**

The general fund base for appropriations in this section is increased by $826,000 in fiscal year 2028 and $708,000 in fiscal year 2029.

Subd. 2. **Coordinated Specialty Care Evaluation**

$250,000 in fiscal year 2027 is for evaluation, provider training, capacity building, and outcome reporting related to the implementation of coordinated specialty care. The base for this appropriation is $250,000 in fiscal year 2028 and $150,000 in fiscal year 2029.

Sec. 7. **CENTRAL OFFICE; OFFICE OF INSPECTOR GENERAL**

Subdivision 1. **Total Appropriation** **$** **-0-** **$** **38,831,000**

Appropriations by Fund

General	-0-	36,818,000
State Government Special Revenue	-0-	2,013,000

Subd. 2. **Base Adjustments**

The general fund base for appropriations in this section is increased by $37,818,000 in fiscal year 2028 and $37,818,000 in fiscal year 2029. The state government special revenue fund base for appropriations in this section is increased by $2,352,000 in fiscal year 2028 and $2,352,000 in fiscal year 2029.

Sec. 8. **FORECASTED PROGRAMS; MEDICAL ASSISTANCE** **$ -0- $ (233,167,000)**

(a) The general fund base for appropriations in this section is decreased by $193,982,000 in fiscal year 2028 and $231,254,000 in fiscal year 2029.

(b) Contingent upon implementation of the administrative service organization model, the base is increased by $8,883,000 in fiscal year 2029 from the general fund to increase medical assistance payment rates.

Sec. 9. **GRANT PROGRAMS; HEALTH CARE GRANTS** **$ -0- $ 1,500,000**

The general fund base for appropriations in this section is increased by $1,750,000 in fiscal year 2028 and $1,125,000 in fiscal year 2029.

Sec. 10. **GRANT PROGRAMS; REFUGEE SERVICES GRANTS** **$ -0- $ 10,000,000**

This is a onetime appropriation.

Sec. 11. **GRANT PROGRAMS; HOUSING AND SUPPORT SERVICES GRANTS** **$ -0- $ 192,000**

$1,250,000 in fiscal year 2027 is for grants to utilize a collaborative model where a housing support provider operating under Minnesota Statutes, section 256I.04, connects eligible individuals receiving integrated community

supports with housing support assistance. This is a onetime appropriation and is available until June 30, 2028.

Sec. 12. **GRANT PROGRAMS; ADULT MENTAL HEALTH GRANTS** **$ -0- $ (1,317,000)**

Sec. 13. **GRANT PROGRAMS; CHILD MENTAL HEALTH GRANTS** **$ -0- $ 361,000**

Sec. 14. Laws 2025, First Special Session chapter 3, article 22, section 2, is amended to read:

Sec. 2. **COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES** **$ 1,380,107,000 $ ~~1,408,374,000~~ 1,411,678,000**

Appropriations by Fund

	2026	2027
General	1,078,643,000	~~1,086,200,000~~ 1,089,504,000
State Government Special Revenue	732,000	732,000
Federal TANF	300,396,000	321,106,000
Family and Medical Benefit Insurance	336,000	336,000

The amounts that may be spent for each purpose are specified in the following sections.

Sec. 15. Laws 2025, First Special Session chapter 3, article 22, section 4, subdivision 1, is amended to read:

Subdivision 1. **Total Appropriation** **$ 134,544,000 $ ~~102,268,000~~ 105,572,000**

Appropriations by Fund

	2026	2027
General	133,376,000	~~101,100,000~~ 104,404,000
State Government Special Revenue	732,000	732,000
Federal TANF	100,000	100,000
Family and Medical Benefit Insurance	336,000	336,000

Sec. 16. Laws 2025, First Special Session chapter 3, article 22, section 4, is amended by adding a subdivision to read:

Subd. 4. **Program Administration Assessment**

$2,500,000 in fiscal year 2027 is from the general fund for an assessment of state, county, and Tribal Nation roles in administering human services programs. This is a onetime appropriation and is available until June 30, 2029.

Sec. 17. Laws 2025, First Special Session chapter 9, article 12, section 21, is amended to read:

Sec. 21. **GRANT PROGRAMS; CHEMICAL DEPENDENCY TREATMENT SUPPORT GRANTS**	**$**	**5,405,000**	**$** ~~**5,405,000**~~ **5,044,000**

Subdivision 1. **Appropriations by Fund**

Appropriations by Fund		
	2026	2027
		~~3,672,000~~
General	3,672,000	3,311,000
Lottery Prize	1,733,000	1,733,000

Subd. 2. **Problem Gambling**

$225,000 in fiscal year 2026 and $225,000 in fiscal year 2027 are from the lottery prize fund for a grant to a state affiliate recognized by the National Council on Problem Gambling. The affiliate must provide services to increase public awareness of problem gambling, education, training for individuals and organizations that provide effective treatment services to problem gamblers and their families, and research related to problem gambling.

Subd. 3. **Todd County Peer Support Grants**

$150,000 in fiscal year 2026 and $150,000 in fiscal year 2027 are for a grant to an organization in Todd County that provides daily peer support and specialized sessions for individuals in substance use recovery, transitioning out of incarceration, or who have experienced trauma. This is a onetime appropriation and is available until June 30, 2028.

Subd. 4. **Opioid Overdose Crisis Grants**

$175,000 in fiscal year 2026 and $175,000 in fiscal year 2027 are for grants to address the opioid overdose crisis in communities and populations that have been historically underserved and disproportionately impacted by opioid-related overdose deaths. Grant funding must support culturally responsive and community-based strategies that address the intergenerational effects of substance use disorder in African American, Native, and African immigrant communities. This is a onetime appropriation and is available until June 30, 2028.

Subd. 5. **Beltrami Opioid Youth and Family Grant**

$100,000 in fiscal year 2026 and $100,000 in fiscal year 2027 are for a grant to Beltrami County to support families and children affected by the opioid epidemic. This is a onetime appropriation and is available until June 30, 2028.

Subd. 6. **Base Level Adjustment**

The general fund base for this section is $3,247,000 in fiscal year 2028 and $3,247,000 in fiscal year 2029.

Sec. 18. **APPROPRIATION; HEALTH CARE SUSTAINABILITY.**

$250,000 in fiscal year 2027 is appropriated to the commissioner of management and budget for a study to evaluate strategies to promote the long-term financial stability of safety net health care providers across Minnesota. This is a onetime appropriation.

Sec. 19. **APPROPRIATION; STATEWIDE CRISIS TELEPHONE SERVICES.**

$1,125,000 in fiscal year 2027 is appropriated from the general fund to the commissioner of health for regional coordination and 24-hour-a-day, seven-day-a-week statewide crisis telephone services.

APPENDIX
Article locations for 26-08139

ARTICLE 1	HEALTH CARE	Page.Ln 2.15
ARTICLE 2	BEHAVIORAL HEALTH	Page.Ln 48.18
ARTICLE 3	HOUSING	Page.Ln 71.5
ARTICLE 4	DEPARTMENT OF HUMAN SERVICES OFFICE OF INSPECTOR GENERAL	Page.Ln 78.2
ARTICLE 5	UNIFORM SERVICE STANDARDS	Page.Ln 94.1
ARTICLE 6	BACKGROUND STUDIES	Page.Ln 154.17
ARTICLE 7	MISCELLANEOUS	Page.Ln 193.1
ARTICLE 8	APPROPRIATIONS	Page.Ln 203.7

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.

(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

(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

(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;

(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.

245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.

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

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

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

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

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

Subd. 3b. **Exception to personal care assistant; requirements.** The personal care assistant for a recipient may be allowed to enroll with a different personal care assistance provider agency upon initiation of a new background study according to this chapter if:

(1) the commissioner determines that a change in enrollment or affiliation of the personal care assistant is needed in order to ensure continuity of services and protect the health and safety of the recipient;

(2) the chosen agency has been continuously enrolled as a personal care assistance provider agency for at least two years;

(3) the recipient chooses to transfer to the personal care assistance provider agency;

(4) the personal care assistant has been continuously enrolled with the former personal care assistance provider agency since the last background study was completed; and

(5) the personal care assistant continues to meet requirements of section 256B.0659, subdivision 11, notwithstanding paragraph (a), clause (3).

Subd. 5. **Other state agencies.** The commissioner shall conduct background studies on applicants and license holders under the jurisdiction of other state agencies who are required in other statutory sections to initiate background studies under this chapter, including the applicant's or license holder's employees and volunteers when required under other statutory sections.

Subd. 6a. **Legal nonlicensed and certified child care programs.** The commissioner shall conduct background studies for each child care background study subject as defined in section 245C.02, subdivision 6a, as required by sections 142C.09 and 142E.16.

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.

Subd. 9a. **Exception to support worker requirements for continuity of services.** The support worker for a participant may enroll with a different Community First Services and Supports (CFSS) agency-provider or Financial Management Services (FMS) provider upon initiation, rather than completion, of a new background study according to this chapter if:

(1) the commissioner determines that the support worker's change in enrollment or affiliation is necessary to ensure continuity of services and to protect the health and safety of the participant;

(2) the chosen agency-provider or FMS provider has been continuously enrolled as a CFSS agency-provider or FMS provider for at least two years or since the inception of the CFSS program, whichever is shorter;

(3) the participant served by the support worker chooses to transfer to the CFSS agency-provider or the FMS provider to which the support worker is transferring;

(4) the support worker has been continuously enrolled with the former CFSS agency-provider or FMS provider since the support worker's last background study was completed; and

(5) the support worker continues to meet the requirements of section 256B.85, subdivision 16, notwithstanding paragraph (a), clause (1).

245C.04 WHEN BACKGROUND STUDY MUST OCCUR.

Subd. 2. **Other state agencies.** Applicants and license holders under the jurisdiction of other state agencies who are required in other statutory sections to initiate background studies under this chapter must submit completed background study forms to the commissioner before the background study subject begins in a position allowing direct contact in the licensed program or, where applicable, prior to being employed.

Subd. 3. **Personal care provider organizations.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 2, at least upon application for initial enrollment under sections 256B.0651 to 256B.0654 and 256B.0659.

(b) Organizations required to initiate background studies under sections 256B.0651 to 256B.0654 and 256B.0659 for individuals described in section 245C.03, subdivision 2, must submit a completed background study request to the commissioner using the electronic system known as NETStudy before those individuals begin a position allowing direct contact with persons served by the organization.

(c) Organizations required to initiate background studies under sections 256B.0651 to 256B.0654 and 256B.0659 for individuals described in section 245C.03, subdivision 2, must initiate a new background study through NETStudy when an individual returns to a position requiring a background study following an absence of 120 or more consecutive days.

Subd. 4. **Supplemental nursing services agencies.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 3, at least upon application for registration under section 144A.71, subdivision 1.

(b) Each supplemental nursing services agency must initiate background studies using the electronic system known as NETStudy before an individual begins a position allowing direct contact with persons served by the agency and annually thereafter.

(c) A supplemental nursing services agency that initiates background studies through NETStudy 2.0 is exempt from the requirement to initiate annual background studies under paragraph (b) for individuals who are on the agency's active roster.

Subd. 5. **Personnel agencies; educational programs; professional services agencies.** (a) Agencies, programs, and individuals who initiate background studies under section 245C.03, subdivision 4, must initiate the studies annually using the electronic system known as NETStudy.

(b) Agencies, programs, and individuals who initiate background studies through NETStudy 2.0 are exempt from the requirement to initiate annual background studies under paragraph (a) for individuals who are on the agency's or program's active roster.

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

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

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

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

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

Subd. 7. **New study required with legal name change.** (a) For a background study completed on an individual required to be studied under section 245C.03, the license holder or other entity that initiated the background study must initiate a new background study using the electronic system known as NETStudy when an individual who is affiliated with the license holder or other entity undergoes a legal name change.

(b) For background studies subject to a fee paid through the NETStudy system, the entity that initiated the study may initiate a new study under paragraph (a) or notify the commissioner of the name change through a notice to the commissioner.

Subd. 8. **Current or prospective contractors serving multiple family child care license holders.** (a) Before the implementation of NETStudy 2.0, current or prospective contractors who are required to have a background study under section 245C.03, subdivision 1, who provide services for multiple family child care license holders in a single county, and will have direct contact with children served in the family child care setting are required to have only one background study which is transferable to all family child care programs in that county if:

(1) the county agency maintains a record of the contractor's background study results which verify the contractor is approved to have direct contact with children receiving services;

(2) the license holder contacts the county agency and obtains notice that the current or prospective contractor is in compliance with background study requirements and approved to have direct contact; and

(3) the contractor's background study is repeated every two years.

(b) For a family child care license holder operating under NETStudy 2.0, the license holder's active roster shall be the system used to document when a background study subject is affiliated with the license holder.

Subd. 9. **Community first services and supports organizations.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 9, at least upon application for initial enrollment under section 256B.85.

(b) Before an individual described in section 245C.03, subdivision 9, begins a position allowing direct contact with a person served by an organization required to initiate a background study under section 256B.85, the organization must receive a notice from the commissioner that the support worker is:

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

(2) disqualified, but the individual has received a set-aside of the disqualification under section 245C.22.

Subd. 10. **Child protection workers or social services staff having responsibility for child protective duties.** The commissioner shall conduct background studies of employees of county social services and local welfare agencies having responsibility for child protection duties when the background study is initiated according to section 260E.36, subdivision 3.

Subd. 11. **Children's residential facilities and foster residence settings.** Applicants and license holders for children's residential facilities and foster residence settings must submit a background study request to the commissioner using the electronic system known as NETStudy 2.0:

(1) before the commissioner issues a license to an applicant;

(2) before an individual age 13 or older, who is not currently receiving services from the licensed facility or setting, may live in the licensed program or setting;

(3) before a volunteer has unsupervised direct contact with persons that the program serves;

(4) before an individual becomes a controlling individual as defined in section 245A.02, subdivision 5a;

(5) before an adult, regardless of whether or not the individual will have direct contact with persons served by the facility, begins working in the facility or setting;

(6) when directed to by the commissioner for an individual who resides in the household as described in section 245C.03, subdivision 1, paragraph (a), clause (5); and

(7) when directed to by the commissioner for an individual who may have unsupervised access to children or vulnerable adults as described in section 245C.03, subdivision 1, paragraph (a), clause (6).

Subd. 12. **Early intensive developmental and behavioral intervention providers.** Providers required to initiate background studies under section 245C.03, subdivision 15, must initiate a study using the electronic system known as NETStudy 2.0 before the individual begins in a position allowing direct contact with persons served by the provider or before the individual becomes an operator or acquires five percent or more ownership.

Subd. 13. **Recuperative care providers.** Providers required to initiate background studies under section 245C.03, subdivision 16, must initiate a study using the electronic system known as NETStudy 2.0 before the individual begins in a position allowing direct contact with persons served by the provider, before the individual becomes an operator of the provider, or before the individual acquires an ownership interest of at least five percent in the provider.

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.

(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.0371 PERFORMANCE BENCHMARKS FOR DENTAL ACCESS; CONTINGENT DENTAL ADMINISTRATOR.

Subdivision 1. **Benchmark for dental access.** For coverage years 2022 to 2024, the commissioner shall establish a performance benchmark under which at least 55 percent of children and adults who were continuously enrolled for at least 11 months in either medical assistance or MinnesotaCare through a managed care or county-based purchasing plan received at least one dental visit during the coverage year.

Subd. 2. **Corrective action plan.** For coverage years 2022 to 2024, if a managed care or county-based purchasing plan under contract with the commissioner to provide dental services under this chapter or chapter 256L has a rate of dental utilization that is ten percent or more below the performance benchmark specified in subdivision 1, the commissioner shall require the managed care or county-based purchasing plan to submit a corrective action plan to the commissioner describing how the entity intends to increase dental utilization to meet the performance benchmark. The managed care or county-based purchasing plan must:

(1) provide a written corrective action plan to the commissioner for approval;

(2) implement the plan; and

(3) provide the commissioner with documentation of each corrective action taken.

Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall determine the extent to which managed care and county-based purchasing plans in the aggregate meet the performance benchmark specified in subdivision 1 for coverage year 2024. If managed care and county-based purchasing plans in the aggregate fail to meet the performance benchmark, the commissioner, after issuing a request for information followed by a request for proposals, shall contract with a dental administrator to administer dental services beginning January 1, 2028, for recipients of medical assistance and MinnesotaCare who are served under fee-for-service and persons receiving services through managed care plans.

(b) The dental administrator must provide administrative services, including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and reviews of medical necessity for dental services;

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services statewide;

(8) performance measurement;

(9) quality improvement and evaluation;

(10) management of third-party liability requirements; and

(11) establishment of grievance and appeals processes for providers and enrollees that the commissioner can monitor.

(c) Dental administrator payments to contracted dental providers must be based on rates recommended by the dental access working group. If the recommended rates are not established in law prior to July 1, 2027, dental administrator payments to contracted dental providers must be at the rates established under sections 256B.76 and 256L.11.

(d) Recipients must be given a choice of dental provider, including any provider who agrees to provider participation requirements and payment rates established by the commissioner and dental

administrator. The dental administrator must comply with the network adequacy and geographic access requirements that apply to managed care plans for dental services under section 62K.14.

(e) The contract with the dental administrator must include performance benchmarks, accountability measures, and progress rewards based on the recommendations from the dental access working group.

(f) Notwithstanding the contract term limits under section 16C.06, subdivision 3b, the commissioner may extend the implementation contract for the single dental administrator under paragraph (a) up to three years from the date of execution and may contract with the same contractor as the single dental administrator for up to five years, beginning in 2028.

Subd. 4. **Dental utilization report.** (a) The commissioner shall submit an annual report beginning March 15, 2022, and ending March 15, 2026, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that includes the percentage for adults and children one through 20 years of age for the most recent complete calendar year receiving at least one dental visit for both fee-for-service and the prepaid medical assistance program. The report must include:

(1) statewide utilization for both fee-for-service and for the prepaid medical assistance program;

(2) utilization by county;

(3) utilization by children receiving dental services through fee-for-service and through a managed care plan or county-based purchasing plan; and

(4) utilization by adults receiving dental services through fee-for-service and through a managed care plan or county-based purchasing plan.

(b) The report must also include a description of any corrective action plans required to be submitted under subdivision 2.

(c) The initial report due on March 15, 2022, must include the utilization metrics described in paragraph (a) for each of the following calendar years: 2017, 2018, 2019, and 2020.

(d) In the annual report due on March 15, 2023, and in each report due thereafter, the commissioner shall include the following:

(1) the number of dentists enrolled with the commissioner as a medical assistance dental provider and the congressional district or districts in which the dentist provides services;

(2) the number of enrolled dentists who provided fee-for-service dental services to medical assistance or MinnesotaCare patients within the previous calendar year in the following increments: one to nine patients, ten to 100 patients, and over 100 patients;

(3) the number of enrolled dentists who provided dental services to medical assistance or MinnesotaCare patients through a managed care plan or county-based purchasing plan within the previous calendar year in the following increments: one to nine patients, ten to 100 patients, and over 100 patients; and

(4) the number of dentists who provided dental services to a new patient who was enrolled in medical assistance or MinnesotaCare within the previous calendar year.

(e) The report due on March 15, 2023, must include the metrics described in paragraph (d) for each of the following years: 2017, 2018, 2019, 2020, and 2021.

256B.051 HOUSING STABILIZATION SERVICES.

Subdivision 1. **Purpose.** Housing stabilization services are established to provide housing stabilization services to an individual with a disability that limits the individual's ability to obtain or maintain stable housing. The services support an individual's transition to housing in the community and increase long-term stability in housing, to avoid future periods of being at risk of homelessness or institutionalization.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Agency" means the legal entity that is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide housing stabilization services and that has the legal responsibility to ensure that its employees carry out the responsibilities defined in this section.

(c) "At-risk of homelessness" means (1) an individual that is faced with a set of circumstances likely to cause the individual to become homeless, or (2) an individual previously homeless, who will be discharged from a correctional, medical, mental health, or treatment center, who lacks sufficient resources to pay for housing and does not have a permanent place to live.

(d) "Commissioner" means the commissioner of human services.

(e) "Employee of an agency" or "employee" means any person who is employed by an agency temporarily, part time, or full time and who performs work for at least 80 hours in a year for that agency in Minnesota. Employee does not include an independent contractor.

(f) "Homeless" means an individual or family lacking a fixed, adequate nighttime residence.

(g) "Individual with a disability" means:

(1) an individual who is aged, blind, or disabled as determined by the criteria used by the title 11 program of the Social Security Act, United States Code, title 42, section 416, paragraph (i), item (1); or

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

(h) "Institution" means a setting as defined in section 256B.0621, subdivision 2, clause (3), and the Minnesota Security Hospital as defined in section 253.20.

Subd. 3. **Eligibility.** An individual with a disability is eligible for housing stabilization services if the individual:

(1) is 18 years of age or older;

(2) is enrolled in medical assistance;

(3) has income at or below 150 percent of the federal poverty level;

(4) has an assessment of functional need that determines a need for services due to limitations caused by the individual's disability;

(5) resides in or plans to transition to a community-based setting as defined in Code of Federal Regulations, title 42, section 441.301 (c); and

(6) has housing instability evidenced by:

(i) being homeless or at-risk of homelessness;

(ii) being in the process of transitioning from, or having transitioned in the past six months from, an institution or licensed or registered setting;

(iii) being eligible for waiver services under chapter 256S or section 256B.092 or 256B.49; or

(iv) having been identified by a long-term care consultation under section 256B.0911 as at risk of institutionalization.

Subd. 4. **Assessment requirements.** (a) An individual's assessment of functional need must be conducted by one of the following methods:

(1) an assessor according to the criteria established in section 256B.0911, subdivisions 17 to 21, 23, 24, and 29 to 31, using a format established by the commissioner;

(2) documented need for services as verified by a professional statement of need as defined in section 256I.03, subdivision 12; or

(3) according to the continuum of care coordinated assessment system established in Code of Federal Regulations, title 24, section 578.3, using a format established by the commissioner.

(b) An individual must be reassessed within one year of initial assessment, and annually thereafter.

Subd. 5. **Housing stabilization services.** (a) Housing stabilization services include housing transition services, housing and tenancy sustaining services, housing consultation services, and housing transition costs.

(b) Housing transition services are defined as:

(1) tenant screening and housing assessment;

(2) assistance with the housing search and application process;

(3) identifying resources to cover onetime moving expenses;

(4) ensuring a new living arrangement is safe and ready for move-in;

(5) assisting in arranging for and supporting details of a move; and

(6) developing a housing support crisis plan.

(c) Housing and tenancy sustaining services include:

(1) prevention and early identification of behaviors that may jeopardize continued stable housing;

(2) education and training on roles, rights, and responsibilities of the tenant and the property manager;

(3) coaching to develop and maintain key relationships with property managers and neighbors;

(4) advocacy and referral to community resources to prevent eviction when housing is at risk;

(5) assistance with housing recertification process;

(6) coordination with the tenant to regularly review, update, and modify the housing support and crisis plan; and

(7) continuing training on being a good tenant, lease compliance, and household management.

(d) Housing consultation services assist an individual with developing a person-centered plan when the individual is not eligible to receive person-centered planning through any other service.

(e) Housing transition costs are available to persons transitioning from a provider-controlled setting to the person's own home and include:

(1) security deposits; and

(2) essential furnishings and supplies.

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

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

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

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

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

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

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

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

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

Subd. 6a. **Pre-enrollment risk assessment.** (a) Prior to enrolling a housing stabilization services agency, the commissioner must complete a pre-enrollment risk assessment of the agency seeking

to enroll to confirm the agency's eligibility and the agency's ability to meet the requirements of this section. In completing this assessment, the commissioner must consider:

(1) the potential agency's history of performing services similar to those required by this section;

(2) whether the services require the potential agency to perform duties at a significantly increased scale and, if so, whether the potential agency has the capability and organizational capacity to do so;

(3) the potential agency's financial information and internal controls; and

(4) the potential agency's compliance with other state and federal requirements, including but not limited to debarment and suspension status, and standing with the secretary of state, if applicable.

(b) At any time when completing the pre-enrollment risk assessment, if the commissioner determines that the potential agency does not have a history of performing similar duties, the potential agency does not demonstrate the capability and capacity to perform the duties at the scale and pace required, or the results of the financial information review raise concern, then the commissioner may deem the potential agency ineligible and deny or rescind enrollment. A potential agency may appeal a decision regarding its eligibility in writing within 30 business days. The commissioner must notify each potential agency of the commissioner's final decision regarding its eligibility.

(c) This subdivision is effective July 1, 2025. Any housing stabilization services provider enrolled before July 1, 2025, that billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment on a schedule determined by the commissioner and no later than July 1, 2026, to remain eligible. Any provider enrolled before July 1, 2025, that has not billed for services on or after January 1, 2024, must complete the pre-enrollment risk assessment to remain eligible.

Subd. 6b. **Requirements for provider enrollment.** (a) Effective January 1, 2027, to enroll as a housing stabilization services provider agency, an agency must require all owners of the agency who are active in the day-to-day management and operations of the agency and managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

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

(2) enrollment requirements;

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

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the agency and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the agency. If an individual moves to another housing stabilization services provider agency and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) Any housing stabilization services provider agency enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

Subd. 7. **Housing support supplemental service rates.** Supplemental service rates for individuals in settings according to sections 144D.025, 256I.04, subdivision 3, paragraph (a), clause (3), and 256I.05, subdivision 1g, shall be reduced by one-half over a two-year period. This reduction only applies to supplemental service rates for individuals eligible for housing stabilization services under this section.

Subd. 8. **Documentation requirements.** (a) An agency must document delivery of all services. The agency must collect and maintain the required information either electronically or in paper form and must produce the documents containing the information upon request by the commissioner.

(b) Documentation of a delivered service must be in English and must be legible according to the standard of a reasonable person.

(c) If the service is reimbursed at an hourly or specified minute-based rate, each documentation of the provision of a service, unless otherwise specified, must include:

(1) the full name of the service recipient;

(2) the date the documentation occurred;

(3) the day, month, and year the service was provided;

(4) the start and stop times with a.m. and p.m. designations, except for housing consultation services;

(5) the service name or description of the service provided for each date of service;

(6) the name, signature, and title, if any, of the employee of the agency that provided the service. If the service is provided by multiple employees, the agency may designate an employee responsible for verifying services and completing the documentation required by this paragraph;

(7) the signature of the service recipient and a statement that the recipient's signature is verification of the accuracy of the service documentation; and

(8) a statement that it is a federal crime to provide false information on housing stabilization services billings for medical assistance payments.

Subd. 9. **Service limits.** (a) Housing stabilization services must not exceed the limits in clauses (1) to (4):

(1) housing transition services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing and tenancy sustaining services;

(2) housing and tenancy sustaining services are limited to 100 hours annually per recipient and are not billable when a recipient is concurrently receiving housing transition services;

(3) housing consultation services are available once annually per recipient and must be provided in person. Additional sessions of housing consultation services may be authorized by the commissioner if the recipient becomes homeless, the recipient experiences a significant change in condition that impacts the recipient's housing, or the recipient requests an update or change to the recipient's plan; and

(4) housing transition costs are limited to $3,000 annually.

(b) Remote support cannot be used for more than a total of 20 percent of all housing transition services and housing and tenancy sustaining services provided to a recipient in a calendar month and is limited to audio-only and accessible video-based platforms. A recipient may refuse, stop, or suspend the use of remote support at any time.

Subd. 10. **Service limit exceptions.** If a recipient requires services exceeding the limits described in subdivision 9, a provider may request authorization for additional hours in a format prescribed by the commissioner. Requests must specify the number of additional hours being requested to meet the recipient's needs and include sufficient documentation to justify the increase to billable hours. Exceptions to service limits are not allowed on the sole basis of changing providers and are limited to recipients who:

(1) become or are at risk of becoming homeless or institutionalized due to a significant change in condition;

(2) have a history of long-term homelessness;

(3) have a history of domestic violence; or

(4) have a criminal background that is a barrier to obtaining housing.

256B.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;

(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;

(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.

(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.

(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 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.

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;

(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.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 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.

(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;

(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 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.

(b) Required documentation must be completed for each individual provider and service modality for each day a child receives a service under subdivision 2, paragraph (b).

256B.695 COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE PROGRAM.

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

(b) "CARMA" means the county-administered rural medical assistance program established under this section.

(c) "Commissioner" means the commissioner of human services.

(d) "Eligible individual" means an individual who is:

(1) residing in a county administering CARMA; and

(2) eligible for medical assistance, MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), or Special Needs Basic Care (SNBC).

(e) "Enrollee" means an individual enrolled in CARMA.

(f) "PMAP" means the prepaid medical assistance program under section 256B.69.

(g) "Rural county" has the meaning given to "rural area" in Code of Federal Regulations, title 42, section 438.52.

Subd. 2. **Program established.** CARMA is established to:

(1) provide a county-owned and county-administered alternative to PMAP;

(2) facilitate integration of health care, public health, and social services to address health-related social needs in rural communities;

(3) account for the fewer enrollees and local providers of health care and community services in rural communities; and

(4) promote accountability for health outcomes, health equity, customer service, community outreach, and cost of care.

Subd. 3. **County participation.** Each county or group of counties authorized under section 256B.692 may administer CARMA for any or all eligible individuals as an alternative to PMAP, MinnesotaCare, MSHO, MSC+, or SNBC programs. Counties choosing and authorized to administer CARMA are exempt from the procurement process as required under section 256B.69.

Subd. 4. **Oversight and regulation.** CARMA is governed by sections 256B.69 and 256B.692, unless otherwise provided for under this section. The commissioner must develop and implement a procurement process requiring applications from county-based purchasing plans interested in offering CARMA. The procurement process must require county-based purchasing plans to demonstrate compliance with federal and state regulatory requirements and the ability to meet the goals of the program set forth in subdivision 2. The commissioner must review and approve or disapprove applications.

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

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

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

(d) The commissioner may offer a second health plan other than, and in addition to, CARMA to eligible individuals when another health plan is required by federal law or rule. The commissioner may offer a replacement plan to eligible individuals, as determined by the commissioner, when counties administering CARMA have their contract terminated for cause.

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

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

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

Subd. 6. **Benefits and services.** (a) Counties or groups of counties administering CARMA must cover all benefits and services required to be covered by medical assistance under section 256B.0625.

(b) Counties or groups of counties administering CARMA may reimburse enrollees directly for out-of-pocket costs incurred obtaining assessed HRSN services provided by nontraditional providers

who are unable to accept payment via traditional health insurance methods. Enrollees must not be reimbursed for out-of-pocket costs paid to providers eligible to enroll.

Subd. 7. **Payment.** (a) The commissioner, in consultation with counties and groups of counties administering CARMA, must develop a mechanism for making payments to counties and groups of counties that administer CARMA. The payment mechanism must:

(1) be governed by contracts with terms, including but not limited to payment rates, amended on an as-needed basis;

(2) pay a full-risk monthly capitation payment for services included in CARMA, including the cost for administering CARMA benefits and services;

(3) include risk corridors based on minimum loss ratio, total cost of care, or other metrics;

(4) include a settle-up process tied to the risk corridor arrangement allowing a county or group of counties administering CARMA to retain savings for reinvestment in health care activities and operations to protect against significant losses that a county or group of counties administering CARMA or the state might realize, beginning no sooner than after a county's or group of counties' third year of CARMA operations;

(5) include a collaborative rate-setting process accounting for CARMA experience, regional experience, and the Department of Human Services fee-for-service experience; and

(6) be exempt from section 256B.69, subdivisions 5a, paragraphs (c) and (f), and 5d, and payment for Medicaid services provided under section 256B.69, subdivision 28, paragraph (b), no sooner than three years after CARMA implementation.

(b) Payments for benefits and services under subdivision 6, paragraph (a), must not exceed payments that otherwise would have been paid to health plans under medical assistance for that county or region.

Subd. 8. **Quality measures.** (a) The commissioner and counties and groups of counties administering CARMA must collaborate to establish quality measures for CARMA not to exceed the extent of quality measures required under sections 256B.69 and 256B.692. The measures must include:

(1) enrollee experience and outcomes;

(2) population health;

(3) health equity; and

(4) the value of health care spending.

(b) The commissioner and counties and groups of counties administering CARMA must collaborate to define a quality improvement model for CARMA. The model must include a focus on locally specified measures based on counties' unique needs. The locally specified measures for the county or group of counties administering CARMA must be determined before the commissioner enters into any contract with a county or group of counties.

Subd. 9. **Data and systems integration.** The commissioner and counties and groups of counties administering CARMA must collaborate to:

(1) identify and address barriers that prevent counties and groups of counties administering CARMA from reviewing individual enrollee eligibility information to identify eligibility and to help enrollees apply for other appropriate programs and resources;

(2) identify and address barriers preventing counties and groups of counties administering CARMA from more readily communicating with and educating potential and current enrollees regarding other program opportunities, including helping enrollees apply for those programs and navigate transitions between programs;

(3) develop and test, in counties participating in CARMA, a universal public assistance application form to reduce the administrative barriers associated with applying for and participating in various public programs;

(4) identify and address regulatory and system barriers that may prohibit counties and groups of counties administering CARMA, agencies, and other partners from working together to identify and address an individual's needs;

(5) facilitate greater interoperability between counties and groups of counties administering CARMA, agencies, and other partners to send and receive the data necessary to support CARMA, counties, and local health system efforts to improve the health and welfare of prospective and enrolled populations;

(6) support efforts of counties and groups of counties administering CARMA to incorporate the necessary automation and interoperability to eliminate manual processes when related to the data exchanged; and

(7) support the creation and maintenance by counties and groups of counties administering CARMA of an updated electronic inventory of community resources available to assist the enrollee in the enrollee's HRSN, including an electronic closed-loop referral system.

256B.696 PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT MANAGER.

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

(b) "Managed care enrollees" means medical assistance and MinnesotaCare enrollees receiving coverage from managed care plans.

(c) "Managed care organizations" means health plan companies and county-based purchasing organizations providing coverage to medical assistance and MinnesotaCare enrollees under the managed care delivery system.

(d) "State pharmacy benefit manager" means the pharmacy benefit manager selected pursuant to the procurement process in subdivision 2.

Subd. 2. **Procurement process.** (a) The commissioner must, through a competitive procurement process in compliance with paragraph (b), select a state pharmacy benefit manager to comply with the requirements set forth in subdivision 3. The state pharmacy benefit manager selected under this subdivision must be a prepaid ambulatory health plan, as defined in Code of Federal Regulations, title 42, section 438.2.

(b) When selecting the state pharmacy benefit manager, the commissioner must:

(1) accept applications for entities seeking to become the state pharmacy benefit manager;

(2) establish eligibility criteria an entity must meet in order to become the state pharmacy benefit manager; and

(3) enter into a master contract with a single pharmacy benefit manager.

(c) Applicants for the state pharmacy benefit manager must disclose to the commissioner the following during the procurement process:

(1) any activity, policy, practice, contract, or arrangement of the pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the Department of Human Services or a managed care organization;

(2) all common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager or any of the pharmacy benefit manager's affiliated companies with:

(i) a managed care organization administering medical assistance or MinnesotaCare benefits in Minnesota or an affiliate of the managed care organization;

(ii) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliates;

(iii) a drug wholesaler or distributor and its affiliates;

(iv) a third-party payer and its affiliates; or

(v) a pharmacy and its affiliates;

(3) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in the state with which the pharmacy benefit manager shares common ownership, management, or control, or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in the state; and

(5) any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

Subd. 3. **Contract requirements.** The master contract required under subdivision 2, paragraph (b), clause (3), must include provisions that prohibit the state pharmacy benefit manager from:

(1) requiring, enticing, or coercing an enrollee to obtain pharmacy services, including a prescription drug, from a pharmacy owned or otherwise affiliated with the state pharmacy benefit manager;

(2) communicating to an enrollee, in any manner, that the enrollee is required to obtain pharmacy services or have a prescription dispensed at, or pharmacy services provided by, a particular pharmacy owned or affiliated with the state pharmacy benefit manager if there are other nonaffiliated pharmacies that have the ability to dispense the medication or provide the services and are also in network;

(3) requiring an enrollee to obtain pharmacy services, including a prescription drug, exclusively through a mail order pharmacy;

(4) directly or indirectly retroactively denying or reducing a claim or aggregate of claims for pharmacy services, including prescription drugs, after adjudication of the claim or aggregation of claims; and

(5) paying a rate for pharmacy services, including the prescription drug, that is less than the sum of the following:

(i) the amount of the professional dispensing fee if it were determined pursuant to section 256B.0625, subdivision 13e; and

(ii) either:

(A) the lower of the national average drug acquisition cost or the Minnesota actual acquisition cost under section 256B.0625, subdivision 13e, paragraph (i);

(B) the maximum allowable cost, as described in section 62W.08, if the national average drug acquisition cost and the Minnesota actual acquisition cost are unreported; or

(C) the wholesale acquisition cost minus two percent at the time the drug is administered or dispensed if the costs of subitems (A) and (B) are unreported or unavailable.

Subd. 4. **Prescription drug coverage requirements.** (a) The state pharmacy benefit manager is responsible for processing all point of sale outpatient pharmacy claims under the managed care delivery system. Managed care and county-based purchasing plans must use the state pharmacy benefit manager pursuant to the terms of the master contract required under subdivision 2, paragraph (b), clause (3). The state pharmacy benefit manager selected is the exclusive pharmacy benefit manager used by managed care and county-based purchasing plans when providing coverage to enrollees. The commissioner may require the managed care and county-based purchasing plans and state pharmacy benefit manager to directly exchange data and files for members enrolled with the plans.

(b) The commissioner may require the state pharmacy benefit manager to modify utilization review limitations, requirements, and strategies imposed on prescription drug coverage.

(c) All payment arrangements between the Department of Human Services, managed care plans, county-based purchasing plans, and the state pharmacy benefit manager must comply with state and federal statutes, regulations adopted by the Centers for Medicare and Medicaid Services, and any other agreement between the department and the Centers for Medicare and Medicaid Services. The commissioner may change a payment arrangement to comply with this paragraph.

(d) The commissioner must administer and oversee this section to:

(1) ensure proper administration of prescription drug benefits for managed care enrollees; and

(2) increase the transparency of prescription drug prices and other information for the benefit of pharmacies.

Subd. 5. **Reporting requirements.** (a) The state pharmacy benefit manager must, on request from the commissioner, disclose to the commissioner all sources of payment the state pharmacy benefit manager receives for prescribed drugs, including drug rebates, discounts, credits, clawbacks,

fees, grants, chargebacks, reimbursements, or other financial benefits or payments related to services provided for a managed care or county-based purchasing plan.

(b) Each managed care and county-based purchasing plan must disclose to the commissioner, in the format specified by the commissioner, the entity's administrative costs associated with providing pharmacy services under the managed care delivery system.

(c) The state pharmacy benefit manager must provide a written quarterly report to the commissioner containing the following information from the immediately preceding quarter:

(1) the prices the state pharmacy benefit manager negotiated for prescribed drugs under the managed care delivery system. The prices must include any rebates the state pharmacy benefit manager received from drug manufacturers;

(2) unredacted copies of contracts between the state pharmacy benefit manager and enrolled pharmacies;

(3) any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(4) any changes to the information previously disclosed in accordance with subdivision 2, paragraph (c); and

(5) any other information required by the commissioner.

(d) Data submitted pursuant to paragraph (c), clause (3), are nonpublic data, as defined in section 13.02, subdivision 9.

(e) The commissioner may request and collect additional information and clinical data from the state pharmacy benefit manager.

(f) At the time of contract execution, renewal, or modification, the commissioner must modify the reporting requirements under its managed care contracts as necessary to meet the requirements of this subdivision.

Subd. 6. **Commissioner's program authority.** (a) To accomplish the requirements of subdivision 4, paragraph (d), the commissioner, in consultation with the Formulary Committee established under section 256B.0625, subdivision 13c, has the authority to:

(1) adopt or develop a preferred drug list for managed care plans;

(2) at the commissioner's discretion, engage in price negotiations with prescription drug manufacturers, wholesalers, or group purchasing organizations in place of the state pharmacy benefit manager to obtain price discounts and rebates for prescription drugs for managed care enrollees; and

(3) develop and manage a drug formulary for managed care and county-based purchasing plans.

(b) The commissioner may contract with one or more entities to perform any of the functions described in paragraph (a).

Subd. 7. **Contracts with pharmacies.** (a) The commissioner may review contracts between the state pharmacy benefit manager and pharmacies for compliance with this section and the master contract required under subdivision 2, paragraph (b), clause (3). The commissioner may amend any term or condition of a contract that does not comply with this section or the master contract.

(b) A master contract and a contract between a state pharmacy benefit manager and a pharmacy are nonpublic data, as defined in section 13.02, subdivision 9.

Subd. 8. **Federal approval.** (a) The commissioner must seek any necessary federal approval to implement this section.

(b) The commissioner shall monitor the effect of state directed payments under this section on access to pharmaceutical services in rural and underserved areas of Minnesota. If, for any contract year, federal approval is not received for a state directed payment under this section, the commissioner must adjust payments made to the managed care entity for that contract year to reflect removal of the payment. Contracts between the state pharmacy benefit manager and providers to whom this section applies must allow recovery of payments from those providers if rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from state directed payments under this section. This paragraph expires if federal approval is not received for state directed payments under this section at any time.

Laws 2025, First Special Session chapter 3, article 18, section 3

Sec. 3. **DIRECTION TO COMMISSIONER; INDIAN HEALTH SERVICE ENCOUNTER RATE.**

The commissioner of human services must submit a state plan amendment to the Centers for Medicare and Medicaid Services authorizing housing services as a new service category eligible for reimbursement at the outpatient per-day rate approved by the Indian Health Service. This reimbursement is limited to services provided by facilities of the Indian Health Service and facilities owned or operated by a Tribe or Tribal organization. For the purposes of this section, "housing services" means housing stabilization services as described in Minnesota Statutes, section 256B.051, subdivision 5, paragraphs (a) to (d).