SENATE
STATE OF MINNESOTA
NINETY-FOURTH SESSION

S.F. No. 4476

(SENATE AUTHORS: HOFFMAN)

DATE	D-PG	OFFICIAL STATUS
03/17/2026	6741	Introduction and first reading
		Referred to Human Services
04/21/2026	8759a	Comm report: To pass as amended and re-refer to Finance
05/04/2026	9496a	Comm report: To pass as amended
	9703	Second reading
	9704	Author stricken Rasmusson
05/06/2026	9946a	Special Order: Amended
	9967	Third reading Passed as amended
05/12/2026	10414	Returned from House with amendment
	10415	Senate not concur, conference committee requested
	10535	Senate conferees Hoffman; Fateh; Wiklund; Abeler
05/13/2026	10539	House conferees Schomaker; Gillman; Noor; Keeler
05/17/2026	11364c	Conference committee report, delete everything
	11658	Senate adopted CC report and repassed bill
	11659	Third Reading Repassed
		Presentment date 05/20/26
	11760	Governor's action Approval 05/27/26
	11761	Secretary of State Chapter 121 05/27/26
		Effective date various dates

A bill for an act

relating to state government; modifying provisions relating to continuity of care, long-term care facilities, health care, Department of Human Services Office of Inspector General policy, background studies, uniform services standards, aging and disability services, and electronic visit verification; making conforming changes; authorizing rulemaking; providing for civil penalties; requiring reports; appropriating money; amending Minnesota Statutes 2024, sections 13.46, subdivision 7; 142E.16, by adding a subdivision; 144.1503, subdivision 7; 144.294, subdivision 2; 144A.291, subdivision 2; 144A.471, subdivision 8; 144G.15; 144G.16, by adding a subdivision; 144G.195, subdivision 1; 144G.45, subdivision 3; 245.095, subdivisions 2, 5, as amended, by adding a subdivision; 245.096; 245.462, by adding a subdivision; 245.4661, subdivision 10, by adding subdivisions; 245.4711, subdivision 5; 245.4881, subdivision 5; 245.4882, subdivision 6; 245.735, subdivision 6; 245A.02, subdivisions 5a, 13; 245A.04, subdivisions 2, 2a; 245A.042, by adding a subdivision; 245A.043, subdivision 2; 245A.07, subdivision 2a; 245A.10, by adding a subdivision; 245A.26, subdivisions 3, 4, 5; 245A.65, subdivision 1a; 245C.02, subdivision 18; 245C.03, subdivisions 1, 3a, 9, by adding subdivisions; 245C.04, subdivision 1; 245C.10, subdivision 8; 245C.15, subdivisions 2, 3, 4; 245C.24, subdivision 2; 245D.04, subdivision 3; 245D.081, subdivision 3; 245D.10, subdivision 4; 245D.12; 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, as amended, 8, by adding a subdivision; 245I.23, subdivisions 4, 5, 8, 12, 16, 17; 254A.03, subdivision 2; 254B.17; 256.01, subdivision 21, by adding a subdivision; 256.975, subdivision 7b; 256B.02, by adding a subdivision; 256B.04, subdivisions 5, 10, 23, by adding subdivisions; 256B.0623, subdivisions 1, 3, 12, by adding a subdivision; 256B.0624, subdivisions 1, 4, as amended, by adding a subdivision; 256B.0625, subdivision 17b, by adding a subdivision; 256B.064, subdivisions 1b, 1c, 1d, 2, 3, 4, 5, by adding subdivisions; 256B.0651, subdivision 17; 256B.0659, subdivisions 12, 16, 17, 19; 256B.0671, by adding a subdivision; 256B.073, subdivisions 1, 2, 3, 5, by adding subdivisions; 256B.076, subdivision 1, by adding subdivisions; 256B.0761, subdivisions 2, 3; 256B.0911, subdivision 32, as amended; 256B.092, subdivision 14; 256B.0922, by adding a subdivision; 256B.094, subdivisions 2, 3, 6; 256B.0943, subdivision 2, by adding a subdivision; 256B.0949, subdivision 17, by adding a subdivision; 256B.27, subdivision 3; 256B.49, subdivision 25; 256B.4912, by adding subdivisions; 256B.4914, subdivisions 6, 6a, 6c, 6d, 7b, 9a, 13, by adding subdivisions; 256B.492, by adding a subdivision; 256B.69, subdivisions 5a, 37,

by adding subdivisions; 256B.85, subdivision 23a, by adding subdivisions; 256S.15, by adding a subdivision; 256S.21, by adding subdivisions; 297E.02, subdivision 3; Minnesota Statutes 2025 Supplement, sections 15.013, by adding a subdivision; 144.0724, subdivision 11; 245.4661, subdivision 9; 245.4835, subdivision 2; 245.4871, subdivision 4; 245.735, subdivision 4d; 245A.03, subdivision 2; 245A.04, subdivisions 1, as amended, 7; 245A.043, subdivision 2a; 245A.05; 245A.07, subdivision 3; 245A.10, subdivisions 3, 4; 245A.142, subdivision 3; 245A.242, subdivision 2; 245C.02, subdivision 15a; 245C.05, subdivision 5; 245C.07; 245C.13, subdivision 2; 245C.15, subdivision 4a; 245C.16, subdivision 1; 245C.22, subdivision 5; 245I.04, subdivisions 5, 17, as amended; 245I.06, subdivision 3; 245I.23, subdivisions 7, 10; 254B.02, subdivision 5; 254B.0503, subdivision 1; 254B.0505, by adding a subdivision; 254B.0509, subdivision 2; 256.01, subdivision 2; 256.4792, subdivisions 1, 7, by adding a subdivision; 256B.04, subdivision 21, as amended; 256B.0625, subdivisions 5m, as amended, 17, 18i, 20; 256B.0659, subdivision 21; 256B.0701, subdivision 9; 256B.0911, subdivision 30; 256B.0924, subdivision 6, as amended; 256B.0943, subdivisions 3, 12; 256B.0949, subdivision 16, as amended; 256B.4914, subdivisions 3, 5a, 8, 9; 256B.85, subdivisions 7, 12, 17a; 256I.04, subdivision 2a; 256L.03, subdivision 5, as amended; 260E.03, subdivision 6; 260E.11, subdivision 1; 260E.14, subdivision 1; 626.5572, subdivision 13, as amended; Laws 2021, First Special Session chapter 7, article 13, section 73, as amended; Laws 2025, First Special Session chapter 3, article 8, section 43; article 20, section 19, subdivision 1; article 21, section 3, subdivision 2; Laws 2025, First Special Session chapter 9, article 4, sections 2; 23; 38; 39; 40; 41; 42; 43; 44; 50; 57; Laws 2026, chapter 95, article 4, section 2; article 5, section 23, subdivision 7; proposing coding for new law in Minnesota Statutes, chapters 245A; 245I; 256B; 256R; 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, subdivision 7; 245I.20, subdivision 9; 245I.23, subdivision 23; 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.073, subdivision 4; 256B.0911, subdivision 21; 256B.0921; 256B.0943, subdivisions 4, 5, 5a, 6, 7, 11; Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3, 4d; 245A.10, subdivision 3a; 256B.0701, subdivision 11; 256B.0911, subdivisions 24a, 25a; 256B.0943, subdivisions 1, 9; Minnesota Rules, part 9505.2165, subpart 4.

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

ARTICLE 1

CONTINUITY OF CARE

Section 1. **[256B.045] CONTINUITY OF CARE.**

Subdivision 1. **Definitions.** (a) For purposes of this section and section 256B.046, the following terms have the meanings given.

(b) "Administrative action" means an action undertaken by the commissioner to sanction a provider or obtain monetary recovery under section 256B.064, suspend or revoke a provider's license under section 245A.07, or initiate a payment withhold under section 245.095 or 256B.064.

(c) "Complex transition" means that a recipient, without intensive transition planning and coordination, is likely to experience or has experienced an avoidable hospitalization,

institutionalization, serious clinical deterioration, or loss of housing as a result of an administrative action or serious operational event.

(d) "Lead agency" means the county, Tribe, or managed care organization responsible for administering medical assistance to a recipient.

(e) "Recipient" means an enrollee, participant, resident, or other individual receiving community residential services, family residential services, customized living, 24-hour customized living, integrated community supports, residential substance use disorder treatment services, or residential mental health treatment services under medical assistance.

(f) "Serious operational event" means insolvency, receivership, bankruptcy, abandonment, inability of a provider to safely operate, or any other circumstances disrupting a provider's ability to continue to provide services or operate a service setting.

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

(1) notify each recipient; each recipient's responsible party, if applicable; the lead agency; and the commissioner as soon as possible but no later than 30 days before terminating services to each recipient;

(2) fully cooperate with the commissioner and lead agency in supporting each recipient in transitioning to another provider of each recipient's choice; and

(3) provide each recipient with a copy of the relevant recipient bill of rights or recipient protections, if applicable, as soon as possible but no later than 30 days before terminating services.

(b) Nothing in this section absolves a provider of its obligations under chapters 144A, 144G, 245A, 245D, 245I, and 245G with respect to service suspensions, service terminations, contract terminations, and coordinated moves. The commissioner of health, the commissioner of human services, or both, may impose any sanctions available under law for violations of state statute or a licensing requirement even if the provider complies with this section and section 256B.046.

Subd. 3. **Lead agency duties.** (a) When a provider is subject to an administrative action or serious operational event, the lead agency must:

(1) inform the appropriate ombudsperson's office for each recipient currently receiving services, if applicable, that the recipient's service provider is subject to an administrative action or is experiencing a serious operational event; and

(2) directly notify each recipient who receives services from the provider that the recipient's service provider is subject to an administrative action or is experiencing a serious operational event.

(b) When a service provider provides notice under subdivision 2 that it is unable to continue to provide services to a recipient due to an administrative action or serious operational event, the lead agency must assist the provider in developing a continuity of care plan to facilitate the recipient's transition to another provider of the recipient's choice. The continuity of care plan must be developed through a person-centered process and include alternative service options, settings, and service providers with known service capacity. The lead agency must complete and receive approval from the recipient of the continuity of care plan no later than 14 days following the notification under subdivision 2.

(c) When a lead agency identifies a recipient's transition as a complex transition under section 256B.046, the lead agency must develop a complex transition plan and cooperate with and provide information to the commissioner as requested so that the commissioner can ensure each recipient receives continuity of medically necessary services and supports through a safe and orderly transition to an appropriate alternative service provider.

(d) Nothing in this section prohibits the lead agency from contacting the commissioner or continuity of care team established in subdivision 4 to request support in ensuring continuity of care.

Subd. 4. **Commissioner's duties.** (a) When the commissioner takes an administrative action against a provider, the commissioner must endeavor to contact the lead agency administering services for potentially affected recipients as soon as practicable and no later than 30 days prior to the administrative action becoming effective. The commissioner must ensure that the lead agency is taking appropriate steps to ensure continuity of care and that the affected recipients will:

(1) continue to receive needed medically necessary services and supports;

(2) be given free choice of service, service setting, and service provider if the recipient transfers to another service, service setting, or service provider; and

(3) secure safe and stable housing.

(b) The commissioner must establish and maintain a continuity of care team to support continuity of care efforts by lead agencies and providers. The continuity of care team must include personnel from across the Department of Human Services with roles in monitoring and supporting providers and lead agencies, establishing standards for continuity of care,

supporting transition planning processes for individuals with a complex transition designation, and overseeing licensing and program integrity efforts. The commissioner may include personnel from other state agencies and housing support providers necessary to effectively carry out the duties of the continuity of care team.

(c) The continuity of care team must provide support, oversight, and direction to lead agencies and providers when a recipient's transition is identified as a complex transition under section 256B.046.

(d) Nothing in this section prohibits the continuity of care team from providing support to lead agencies, providers, and recipients on continuity of care efforts not covered by this section or section 256B.046.

Sec. 2. **[256B.046] COMPLEX TRANSITIONS.**

Subdivision 1. **Complex transition identification.** (a) The lead agency must work with the provider and commissioner to identify each recipient whose transition is a complex transition. The lead agency and provider must submit to the commissioner a complex transition plan as described in subdivision 2 for each recipient identified under this paragraph.

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

Subd. 2. **Complex transition plan.** (a) The commissioner must develop guidance on effective complex transition planning and make a complex transition plan template available to providers and lead agencies. The plan template must include data fields to collect at least the following information:

(1) recipient's name and acuity level;

(2) stabilization actions to be taken to prevent gaps in care and housing;

(3) names, contact information, and known capacity of alternative providers;

(4) transition timelines, transportation, and handoff procedures;

(5) a communication plan for each recipient, the recipient's family, and the recipient's guardian, if applicable, including language access; and

(6) steps to be taken to coordinate with lead agencies, case managers, and ombudsperson offices, when applicable.

(b) Providers and lead agencies must use the plan template described in paragraph (a) to develop a complex transition plan for each recipient whose transition is identified as a complex transition.

Subd. 3. **Complex transition planning.** (a) A lead agency that receives notice from a provider of a serious operational event must assist a recipient with an identified complex transition to develop a complex transition plan through a person-centered process. The complex transition plan must include alternative service options, service settings, service providers with known service capacity, and safe and stable housing options. Within 14 days of receiving notice from a provider of a serious operational event, the lead agency must ensure completion and approval of the complex transition plan by the recipient or the recipient's representative.

(b) A lead agency that receives notice from the commissioner of an administrative action must assist a recipient with an identified complex transition to develop a complex transition plan through a person-centered process. The complex transition plan must include alternative service options, service settings, service providers with known service capacity, and safe and stable housing options. Within 14 days of receiving notice from the commissioner of an administrative action, other than notice of actions necessary to protect the health and safety of a recipient, the lead agency must ensure completion and approval of the complex transition plan by the recipient or the recipient's representative. For any administrative action necessary to protect the health and safety of a recipient, the lead agency must immediately take all necessary actions to ensure the health and safety of the recipient.

(c) Lead agencies must, as soon as possible, convene a meeting of representatives of the recipient; the recipient's representative, if appropriate; the lead agency; the provider, if the commissioner determines the provider's participation is appropriate; and the commissioner to discuss implementation of the complex transition plan.

(d) While a complex transition plan is active, lead agencies must convene every 14 days for a status meeting to provide a progress report to the commissioner on implementation of the complex transition plan.

Subd. 4. **No alternative services notification.** (a) If the lead agency does not identify an alternative service option, service setting, service provider, or safe and stable housing option, the lead agency must notify the commissioner and the commissioner of health, if applicable.

(b) Upon receiving a notification from the lead agency that the lead agency has failed to arrange for an alternative service option, service setting, service provider, or safe and

stable housing option as required under the complex transition plan, the commissioner must determine if:

(1) there exists a good cause under Code of Federal Regulations, title 42, section 455.23(e) or (f), to not suspend payments under section 256B.064, subdivision 2;

(2) a delay in the implementation date of an administrative action is needed to support complex transition planning under this section; or

(3) there is cause to petition the district court in Ramsey County under section 245A.13 to be appointed receiver to operate a residential program.

Subd. 5. **Publishing data on continuity of care planning and complex transitions.** (a) The commissioner must maintain on the Department of Human Services' website a dashboard sharing data on the:

(1) number of active continuity of care plans;

(2) number of recipients included in an active continuity of care plan;

(3) average time between approval of a continuity of care plan and closure of that plan;

(4) number of active complex transition plans;

(5) number of complex transition plans completed before the provider ceases providing services or closes a setting, on an annual basis;

(6) number of complex transition plans completed after the provider ceases providing services or closes a setting, on an annual basis;

(7) number of complex transition plans that were not successfully completed, on an annual basis;

(8) number of notifications received by lead agencies under subdivision 3, paragraph (a); and

(9) number of notifications received by lead agencies under subdivision 3, paragraph (b).

(b) The commissioner must include functionality within the dashboard to filter data by region or county, provided the filtering functionalities comply with federal or state laws regarding the protection of personal health information and personally identifiable information.

Sec. 3. Minnesota Statutes 2024, section 256B.0651, subdivision 17, is amended to read:

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

~~(b) In the event of a payment withhold from a home care provider, a suspension of participation, or a termination of participation of a home care provider under section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all recipients with active service agreements with the provider. At the commissioner's request, the lead agencies must contact recipients to ensure that the recipients are continuing to receive needed care, and that the recipients have been given free choice of provider if they transfer to another home care provider. In addition, the commissioner or the commissioner's delegate may directly notify recipients who receive care from the provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that notification is necessary to protect the welfare of the recipients. For purposes of this subdivision, "lead agencies" means counties, tribes, and managed care organizations.~~

Sec. 4. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision to read:

Subd. 38. **Duties when a provider is no longer able to provide services.** When a provider is subject to a serious operational event or administrative action under section 256B.045, managed care and county-based purchasing plans must:

(1) follow the continuity of care planning and complex transition planning requirements under sections 256B.045 and 256B.046;

(2) honor existing services authorizations when clinically appropriate for continuity and safe transfer of services; and

(3) ensure timely contracting or single-case arrangements to prevent services gaps.

Sec. 5. Minnesota Statutes 2024, section 256B.85, subdivision 23a, is amended to read:

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

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

(c) Agency-providers of CFSS services or FMS providers must ~~provide each participant with a copy of participant protections in subdivision 20c at least 30 days prior to terminating services to a participant, if the termination results from sanctions under this subdivision or section 256B.064, such as a payment withhold or a suspension or termination of the provider enrollment number. If a CFSS agency-provider, FMS provider, or consultation services provider determines it is unable to continue providing services to a participant because of an action under this subdivision or section 256B.064, the agency-provider, FMS provider, or consultation services provider must notify the participant, the participant's representative, and the commissioner 30 days prior to terminating services to the participant, and must assist the commissioner and lead agency in supporting the participant in transitioning to another CFSS agency-provider, FMS provider, or consultation services provider of the participant's choice~~ meet the recipient protection requirements under section 256B.045 when subject to an administrative action or a serious operational event as defined in section 256B.045, subdivision 1.

~~(d) In the event the commissioner withholds payment from a CFSS agency-provider, FMS provider, or consultation services provider, or suspends or terminates a provider enrollment number of a CFSS agency-provider, FMS provider, or consultation services provider under this subdivision or section 256B.064, the commissioner may inform the Office of Ombudsman for Long-Term Care and the lead agencies for all participants with active service agreements with the agency-provider, FMS provider, or consultation services~~

~~provider. At the commissioner's request, the lead agencies must contact participants to ensure that the participants are continuing to receive needed care, and that the participants have been given free choice of agency-provider, FMS provider, or consultation services provider if they transfer to another CFSS agency-provider, FMS provider, or consultation services provider. In addition, the commissioner or the commissioner's delegate may directly notify participants who receive care from the agency-provider, FMS provider, or consultation services provider that payments have been or will be withheld or that the provider's participation in medical assistance has been or will be suspended or terminated, if the commissioner determines that the notification is necessary to protect the welfare of the participants.~~

Sec. 6. **HOUSING SUPPORT CAPACITY-BUILDING GRANTS.**

(a) The commissioner of human services must establish capacity-building grants for housing support providers assisting recipients of medical assistance home and community-based services, including but not limited to integrated community supports, to prevent homelessness and institutionalization. The commissioner must award at least one grant to a qualified grant recipient located outside of the seven-county metropolitan area. The commissioner must include in the grant contract that the money awarded under the grant must not be used for any purpose other than the purposes specified in paragraph (c).

(b) Eligible recipients include housing support providers operating in accordance with Minnesota Statutes, section 256I.04.

(c) Capacity-building grants may be used for:

(1) administrative expenses;

(2) the assessment of eligible housing assistance benefits;

(3) housing transition assistance, including supports required due to a change in an individual's medical assistance services or provider; and

(4) the development of regional or collaborative housing support models that enable housing support providers to better support individual choice and access to community-integrated housing options.

(d) Grant recipients must report data and results to the commissioner, in a format determined by the commissioner, including:

(1) the percent increase in provider capacity;

(2) the number of referrals received and accepted, by medical assistance home and community-based service type;

(3) reasons for a referral;

(4) housing status for all accepted referrals at six months and one year, including the number of individuals residing in community-based settings; and

(5) additional outcomes as necessary to evaluate the effectiveness of the programs and use of funding for the people served.

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

Sec. 7. **DIRECTION TO COMMISSIONER; CONTINUITY OF CARE POLICIES AND PROCEDURES.**

The commissioner of human services must develop policies and procedures lead agencies must follow when developing, implementing, monitoring, and closing a complex transition plan under Minnesota Statutes, section 256B.046. The policies and procedures must include timelines, checklists, and mandatory follow-up with all parties involved in the development and implementation of the plan. The policies and procedures must include documentation requirements sufficient to demonstrate that the planning process and implementation was person-centered and prioritized the needs and informed choice of the service recipient.

ARTICLE 2
LONG-TERM CARE FACILITY

Section 1. Minnesota Statutes 2024, section 144.1503, subdivision 7, is amended to read:

Subd. 7. **Selection process.** The commissioner shall determine a maximum award for grants and loan forgiveness, and shall make selections based on the information provided in the grant application, including the demonstrated need for an applicant provider to enhance the education of its workforce, the proposed employee scholarship or loan forgiveness selection process, the applicant's proposed budget, and other criteria as determined by the commissioner. Notwithstanding any law or rule to the contrary, amounts appropriated for purposes of this section do not cancel and are available until expended~~, except that at the end of each biennium, any remaining amount that is not committed by contract and not needed to fulfill existing commitments shall cancel to the general fund~~.

Sec. 2. Minnesota Statutes 2024, section 144A.291, subdivision 2, is amended to read:

Subd. 2. **Amounts.** (a) Fees may not exceed the following amounts but may be adjusted lower by board direction and are for the exclusive use of the board as required to sustain board operations. The maximum amounts of fees are:

(1) application for licensure, $200;

(2) for a prospective applicant for a review of education and experience advisory to the license application, $100, to be applied to the fee for application for licensure if the latter is submitted within one year of the request for review of education and experience;

(3) state examination, $125;

(4) initial license, $250 ~~if issued between July 1 and December 31, $100 if issued between January 1 and June 30~~;

(5) ~~acting~~ permit, $400;

(6) renewal license or certificate, $250;

(7) duplicate license, permit, or certificate, $50;

(8) reinstatement fee, $250;

~~(9) health services executive initial license, $250;~~

~~(10) health services executive renewal license, $250;~~

~~(11)~~ (9) reciprocity verification fee, $50;

~~(12) second~~ (10) application for shared assignment certificate, $250;

~~(13)~~ (11) continuing education fees:

(i) greater than six hours, $50; and

(ii) seven hours or more, $75;

~~(14)~~ (12) education review, $100;

~~(15)~~ (13) fee to a sponsor for review of individual continuing education seminars, institutes, workshops, or home study courses:

(i) for less than seven clock hours, $30; and

(ii) for seven or more clock hours, $50;

~~(16)~~ (14) fee to a licensee for review of continuing education seminars, institutes, workshops, or home study courses not previously approved for a sponsor and submitted with an application for license renewal:

(i) for less than seven clock hours total, $30; and

(ii) for seven or more clock hours total, $50;

~~(17)~~ (15) late renewal fee, $75;

~~(18)~~ (16) fee to a licensee for verification of licensure status and examination scores, $30;

~~(19)~~ (17) registration as a registered continuing education sponsor, $1,000;

~~(20) mail~~ (18) mailing list labels, $75; and

~~(21)~~ (19) annual assisted living program education provider fee, $2,500.

(b) The revenue generated from the fees must be deposited in an account in the state government special revenue fund.

Sec. 3. Minnesota Statutes 2024, section 144A.471, subdivision 8, is amended to read:

Subd. 8. **Exemptions from home care services licensure.** (a) Except as otherwise provided in this chapter, home care services that are provided by the state, counties, or other units of government must be licensed under this chapter.

(b) An exemption under this subdivision does not excuse the exempted individual or organization from complying with applicable provisions of the home care bill of rights in section 144A.44. The following individuals or organizations are exempt from the requirement to obtain a home care provider license:

(1) an individual or organization that offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, and 256B.0659;

(2) a provider that is licensed by the commissioner of human services to provide semi-independent living services for persons with developmental disabilities under section 252.275 and Minnesota Rules, parts 9525.0900 to 9525.1020;

(3) a provider that is licensed by the commissioner of human services to provide home and community-based services for persons with developmental disabilities under section 256B.092 and Minnesota Rules, parts 9525.1800 to 9525.1930;

(4) an individual or organization that provides only home management services, if the individual or organization is registered under section 144A.482; ~~or~~

(5) an individual who is licensed in this state as a nurse, dietitian, social worker, occupational therapist, physical therapist, or speech-language pathologist who provides health care services in the home independently and not through any contractual or employment relationship with a home care provider or other organization; or

(6) a federally qualified health center as defined in section 145.9269, when providing nursing services described in United States Code, title 42, section 1395x(aa)(1)(C).

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

Sec. 4. Minnesota Statutes 2024, section 144G.15, is amended to read:

144G.15 CONSIDERATION OF APPLICATIONS.

Subdivision 1. **Consideration.** (a) Before issuing a provisional license or license or renewing a license, the commissioner shall consider an applicant's compliance history in providing care in this state or any other state in a facility that provides care to children, the elderly, ill individuals, or individuals with disabilities.

(b) The applicant's compliance history shall include repeat violation, rule violations, and any license or certification involuntarily suspended or terminated during an enforcement process.

(c) Before issuing a provisional license for an assisted living facility with a licensed resident capacity of six or fewer, the commissioner shall also consider the population, size, land use plan, availability of community services, and the number and size of existing licensed assisted living facilities in the town, municipality, or county in which the applicant seeks to operate an assisted living facility.

Subd. 2. **Colocation of certain home and community-based residential settings.** The commissioner must not grant a provisional license for an assisted living facility with a licensed resident capacity of six or fewer until the commissioner of human services determines that the proposed location of the assisted living facility meets the standard described in section 245A.042, subdivision 7. This paragraph applies regardless of the services to be provided in the proposed assisted living facility and regardless of whether any residents of the facility will receive publicly funded services.

Subd. 3. **Grounds for licensing action.** ~~(c)~~ The commissioner may deny, revoke, suspend, restrict, or refuse to renew the license or impose conditions if:

(1) the applicant fails to provide complete and accurate information on the application and the commissioner concludes that the missing or corrected information is needed to determine if a license shall be granted;

(2) the applicant, knowingly or with reason to know, made a false statement of a material fact in an application for the license or any data attached to the application or in any matter under investigation by the department;

(3) the applicant refused to allow agents of the commissioner to inspect its books, records, and files related to the license application, or any portion of the premises;

(4) the applicant willfully prevented, interfered with, or attempted to impede in any way: (i) the work of any authorized representative of the commissioner, the ombudsman for long-term care, or the ombudsman for mental health and developmental disabilities; or (ii) the duties of the commissioner, local law enforcement, city or county attorneys, adult protection, county case managers, or other local government personnel;

(5) the applicant, owner, controlling individual, managerial official, or assisted living director for the facility has a history of noncompliance with federal or state regulations that were detrimental to the health, welfare, or safety of a resident or a client; or

(6) the applicant violates any requirement in this chapter.

~~(d) If a license is denied, the applicant has the reconsideration rights available under section 144G.16, subdivision 4.~~

Sec. 5. Minnesota Statutes 2024, section 144G.16, is amended by adding a subdivision to read:

Subd. 8. **Notice to affected municipality.** (a) No later than five days, excluding weekends and holidays, after issuing a provisional license to an assisted living facility with a licensed resident capacity of six or fewer, the commissioner must provide the following information about the provisional licensee and the facility to the affected municipality or other political subdivision:

(1) business name of the provisional licensee;

(2) street address of the facility;

(3) license category;

(4) licensed resident capacity; and

(5) contact information for an authorized agent of the provisional licensee.

(b) The commissioner may provide notice through electronic communication or by submitting a written document to the official address of the municipality or other political subdivision.

EFFECTIVE DATE. This section is effective July 1, 2026, and applies to provisional licenses issued on or after that date.

Sec. 6. Minnesota Statutes 2024, section 144G.195, subdivision 1, is amended to read:

Subdivision 1. **New license not required.** (a) ~~Beginning March 15, 2025,~~ An assisted living facility with a licensed resident capacity of five residents or fewer may operate under the licensee's current license if the facility is relocated with the approval of the commissioner of health during the period the current license is valid.

(b) A licensee is not required to apply for a new license solely because the licensee receives approval to relocate a facility. The licensee's license for the relocated facility remains valid until the expiration date specified on the existing license. The commissioner of health must apply the licensing and survey cycle previously established for the facility's prior location to the facility's new location.

(c) A licensee must notify the commissioner of health, on a form developed by the commissioner, of the licensee's intent to relocate the licensee's facility and submit a nonrefundable relocation fee of $3,905. The commissioner must deposit all relocation fees in the state treasury to be credited to the state government special revenue fund.

(d) The licensee must obtain plan review approval for the building to which the licensee intends to relocate the facility and a certificate of occupancy from the commissioner of labor and industry or the commissioner of labor and industry's delegated authority for the building. Upon issuance of a certificate of occupancy, the commissioner of health must review and inspect the building to which the licensee intends to relocate the facility ~~and approve or deny the license relocation within 30 calendar days~~ and must request from the commissioner of human services a determination of whether the location to which the licensee intends to relocate complies with the standards described in section 245A.042, subdivision 7. The commissioner of health must approve or deny the license relocation within 30 calendar days after inspecting the building and receiving a determination from the commissioner of human services.

(e) A licensee ~~may only relocate a facility within the geographic boundaries of the municipality in which the facility is currently located or within the geographic boundaries of a contiguous municipality~~ located in the seven-county metropolitan area may not relocate

outside of the seven-county metropolitan area. A licensee located outside of the seven-county metropolitan area may not relocate more than two hours or 120 miles from the licensee's previous location nor relocate within the seven-county metropolitan area.

(f) A licensee may only relocate one time in any three-year period, except that the commissioner may approve an additional relocation within a three-year period upon a licensee's demonstration of an extenuating circumstance, including but not limited to the criteria outlined in section 256B.49, subdivision 28a, paragraph (c).

(g) A licensee that receives approval from the commissioner to relocate a facility must provide each resident with a new assisted living contract and comply with the coordinated move requirements under section 144G.55.

(h) A licensee denied approval by the commissioner of health to relocate a facility may continue to operate the facility in its current location, follow the requirements in section 144G.57 and close the facility, or notify the commissioner of health of the licensee's intent to relocate the facility to an alternative new location. If the licensee notifies the commissioner of the licensee's intent to relocate the facility to an alternative new location, ~~paragraph (c) applies, including~~ all provisions of this section apply, including paragraph (c) and the timelines for approving or denying the license relocation for the alternative new location.

(i) If the commissioner of health approves a relocation under this subdivision, the commissioner must comply with the provisions of section 144G.16, subdivision 8.

Sec. 7. Minnesota Statutes 2024, section 144G.45, subdivision 3, is amended to read:

Subd. 3. **Local laws apply; delegating inspection authority.** (a) Assisted living facilities shall comply with all applicable state and local governing laws, regulations, standards, ordinances, and codes for fire safety, building, and zoning requirements, except a facility with a licensed resident capacity of six or fewer is exempt from rental licensing regulations imposed by any town, municipality, or county.

(b) At the request of a county or local unit of government, the commissioner may delegate to a county agency or local unit of government the commissioner's authority to inspect an existing assisted living facility with a licensed resident capacity of six or fewer that is in the jurisdiction of the county or local unit of government for compliance with applicable physical plant licensing requirements and zoning ordinances. If the commissioner delegates the commissioner's authority to a county agency or local unit of government under this subdivision, the commissioner must execute a formal delegation of authority that clearly specifies what authority is being delegated to the county agency or local unit of government,

that the commissioner is responsible for any costs incurred by the county agency or local unit of government for conducting inspections under delegated authority, and that the county agency or local unit of government must not assess any additional fees for conducting an inspection under delegated authority. When conducting an inspection under delegated authority, the county agency or local unit of government must provide the subject of the inspection with a copy of the delegation of authority.

(c) When a county agency or local unit of government is conducting an inspection under delegated authority as provided in paragraph (b), the county agency or local unit of government and the commissioner must coordinate their inspections to minimize visits to and disruptions of the facility. A county agency or local unit of government conducting an inspection must notify the commissioner of any violations or concerns within ten working days of the inspection. A county agency or local unit of government that conducts inspections under this subdivision must not inspect an assisted living facility more frequently than annually, except a follow-up inspection is permitted before the next annual inspection to verify correction of a violation discovered during the most recent inspection.

(d) The commissioner must ensure that laws, rules, and codes are uniformly enforced throughout the state by reviewing at least every four years each county agency and local unit of government conducting inspections under this subdivision for compliance with this subdivision and other applicable laws and rules. The commissioner must ensure that a county agency or local unit of government to which the commissioner has delegated the commissioner's authority under this subdivision has at all times sufficient expertise to conduct delegated inspections competently, and if the county agency or local unit of government does not, the commissioner must immediately revoke the delegation of authority.

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

Sec. 8. **DIRECTION TO COMMISSIONER OF HEALTH; SMALL ASSISTED LIVING FACILITY LICENSURE.**

(a) The commissioner of health must convene a group of interested parties to examine the licensing requirements under Minnesota Statutes, chapter 144G, for assisted living facilities with a licensed resident capacity of five residents or fewer. The group must develop a new licensing category applicable to such facilities to account for health and safety requirements and practical realities of operating small assisted living facilities that predominantly serve individuals receiving customized living services under the federally approved brain injury, community access for disability inclusion, and elderly waiver plans.

(b) The commissioner must develop draft legislative language to establish a new assisted living license category for facilities with a licensed resident capacity of five residents or fewer.

(c) The commissioner must submit the draft legislation to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by January 1, 2028.

ARTICLE 3
HEALTH CARE

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

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

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

Sec. 2. Minnesota Statutes 2024, section 245.095, is amended by adding a subdivision to read:

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

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

Sec. 3. Minnesota Statutes 2024, section 245.462, is amended by adding a subdivision to read:

Subd. 2a. **Case management contact.** "Case management contact" means interactive communication conducted 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. 4. 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) The case manager must have at least one case management contact in every calendar month 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 case management contact by telephone with the adult client or the adult client's legal representative for more than two consecutive calendar months.

Sec. 5. 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) The case manager must have at least one case management contact in every calendar month with the child, the child's parents, or the child's legal representative.

Sec. 6. Minnesota Statutes 2024, section 245A.02, subdivision 5a, is amended to read:

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

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

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

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

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

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

(b) Controlling individual does not include:

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 1, as amended by Laws 2026, chapter 88, article 1, section 101, is amended to read:

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

chapter and comply with the application procedures in this section and section 245A.043. A license issued pursuant to a change of ownership under section 245A.043 is not subject to any moratorium imposed under section 245A.03, subdivision 7 or 7a, provided the change of ownership does not result in an increase in licensed capacity or service scope.

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

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient because the documents submitted do not meet licensing requirements, the commissioner shall provide the applicant written notice that the application is incomplete or substantially deficient. In the written notice to the applicant the commissioner shall identify documents that are missing or deficient and give the applicant 45 days to resubmit a second application that is substantially complete. An applicant's failure to submit a substantially complete application after receiving notice from the commissioner is a basis for license denial under section 245A.05.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) noncompliance with the provider enrollment agreement or registration requirements for receipt of public funding that is identified through a licensing investigation or licensing

inspection, or noncompliance with a licensing requirement that is a basis of enrollment for reimbursement for a service, may result in:

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

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

(iii) recovery of payments made for the service;

(iv) disenrollment in the public payment program; or

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

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

(1) the licensure application;

(2) the renewal application;

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

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

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

Sec. 8. 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), or (j), 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. 9. Minnesota Statutes 2024, section 245A.042, is amended by adding a subdivision to read:

Subd. 7. **Department of Human Services home and community-based services early and often licensor and compliance team.** (a) The commissioner must establish and maintain a home and community-based services early and often licensor and compliance team to deliver proactive and coordinated support to applicants through the application process and to license holders during the first year of operation of the licensed home and community-based program. The commissioner must ensure that the home and community-based services early and often licensor and compliance team has sufficient staff and resources to perform the functions required under this subdivision. The commissioner must ensure that the licensor and compliance team has members with expertise in licensing requirements and members with expertise in medical assistance enrollment requirements, medical assistance service delivery requirements, and medical assistance billing requirements.

(b) The home and community-based services early and often licensor and compliance team must provide technical assistance to applicants regarding completing and submitting license applications under this chapter and chapter 256D and medical assistance provider enrollment applications under section 256B.04, subdivision 21.

(c) The home and community-based services early and often licensor and compliance team must conduct an initial scheduled technical assistance visit three months after the effective date of an initial license for the purpose of providing technical assistance to the license holder. The team must provide technical assistance related to achieving and maintaining compliance with the applicable laws, rules, and regulations governing the provision of and reimbursement for home and community-based services under this chapter and chapters 245D, 256B, and 256S and waiver plans.

(d) The home and community-based services early and often licensor and compliance team must conduct three unscheduled visits after the beginning of the sixth calendar month following the effective date of an initial license and before the end of the eighteenth month following the effective date of an initial license.

(e) If during the technical assistance visit or during the following three unannounced visits, the team finds that the license holder has failed to achieve compliance with an applicable law, rule, or regulation, and the failure does not imminently endanger the health, safety, or rights of persons served by the program, the team may issue a licensing and compliance review report with recommendations for achieving and maintaining compliance.

(f) Nothing in this subdivision shall be construed to limit the commissioner's authority to:

(1) suspend or revoke a license or issue a fine at any time under section 245A.07 or issue correction orders and make a license conditional for failure to comply with applicable laws, rules, or regulations under section 245A.06 based on the nature, chronicity, or severity of the violation of a law, rule, or regulation and the effect of the violation on the health, safety, or rights of persons served by the program; or

(2) impose a sanction under section 256B.064 based on the nature, chronicity, or severity of the violation of law, rule, or regulation.

Sec. 10. 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), 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), or (j);

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

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

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

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

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

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

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

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

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

(b) The designated manager must be competent to perform the duties as required and must minimally meet the education and training requirements identified in subdivision 2,

paragraph (b), and have a minimum of three years of supervisory level experience in a program that provides care or education to vulnerable adults or children.

Sec. 12. 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.0437.

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

Subd. 46. **Department of Human Services home and community-based services provider support and technical assistance team.** The commissioner must establish and maintain a home and community-based services provider support and technical assistance

team to deliver proactive and coordinated support to home and community-based services providers. The commissioner must ensure that the home and community-based services provider support and technical assistance team has sufficient staff and resources to perform the functions required under this subdivision. The home and community-based services provider support and technical assistance team must:

(1) serve as a provider liaison and help desk for providers' technical, regulatory, and operational questions;

(2) develop training and onboarding materials for home and community-based services providers;

(3) collect data on home and community-based provider challenges;

(4) coordinate the functions of the department, including information technology, licensing, provider enrollment, service delivery oversight, and program integrity oversight to clarify program requirements, provider requirements, and service requirements and to support providers with compliance and prevention of fraud; and

(5) make recommendations to the commissioner regarding changes to the operations of the department or to the design and implementation of home and community-based services that would improve the delivery of services and improve program integrity.

Sec. 14. Minnesota Statutes 2024, section 256B.04, subdivision 5, is amended to read:

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

Sec. 15. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, as amended by Laws 2026, chapter 95, article 4, section 12, 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, and sections 256B.044 to 256B.0448. ~~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.0659, 256B.0701, or 256B.85.~~

Sec. 16. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

(1) is in plain language;

(2) is culturally and linguistically appropriate; and

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

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

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

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

Sec. 17. **[256B.0437] 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) 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 section if the provider remains otherwise eligible.

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

Sec. 18. **[256B.044] PROVIDER ENROLLMENT.**

Subdivision 1. **Designating categorical risk levels.** (a) The commissioner must designate provider types as "limited-risk," "moderate-risk," 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 commissioner must publish a list of provider types and designated categorical risk levels in the Minnesota Health Care Program Provider Manual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 5. **Required on-site inspections.** (a) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated as moderate-risk or high-risk by CMS or the commissioner permit CMS, CMS's agents, or CMS's designated contractors and the state agency, the state agency's agents, or the state agency's designated contractors to conduct unannounced on-site inspections of any provider location.

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

Subd. 6. **Surety bonds.** (a) The commissioner must require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, revalidation, reinstatement, or continued enrollment. Upon new enrollment, or if the provider's medical assistance revenue in the previous calendar year is less than or equal to $300,000, the provider must purchase a surety bond of $50,000. If the provider's medical assistance revenue in the previous calendar year is greater than $300,000, the provider must purchase a surety bond of $100,000. The surety bond must name the Department of Human Services as an obligee, must be purchased new 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.

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

Subd. 7. **Financial capacity.** As a condition of enrolling in medical assistance, the commissioner must require, in a form and manner prescribed by the commissioner, that a provider attest to sufficient financial capacity to operate.

Subd. 8. **Compliance programs.** (a) The commissioner may require, as a condition of enrollment in medical assistance, that a provider in a particular industry, of a particular provider type, or with a particular risk categorization under subdivision 1, establish and maintain a compliance program consistent with federal program integrity guidance issued by CMS or the United States Department of Health and Human Services Office of Inspector General.

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

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

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

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

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

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

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

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

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

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

Sec. 19. **[256B.0441] PROVIDER REVALIDATION.**

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

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

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

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

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

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

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

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

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

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

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

(b) For a provider designated moderate-risk or high-risk, the commissioner must conduct unannounced site visits at each of the provider's enrolled locations under section 256B.044, subdivision 4, no more than 30 days prior to the provider's revalidation due date.

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

Sec. 20. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND TERMINATIONS.**

Subdivision 1. **Suspension of billing privileges.** (a) 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.

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

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

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

Subd. 2. **Revocation for lack of documentation.** (a) 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 the 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.

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

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

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

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

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

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

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

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

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

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

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

Sec. 21. **[256B.0443] PROVIDER PAYMENT WITHHOLDS.**

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

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

Sec. 22. **[256B.0444] ENROLLMENT MORATORIUM FOR HIGH-RISK PROVIDERS.**

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

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

Subd. 2. **Moratorium exceptions.** The commissioner may grant exceptions to a moratorium issued under subdivision 1 and must make publicly available the processes and criteria the commissioner will use to grant exceptions. The commissioner may grant an exception if a county or Tribal agency submits a request for an exception to the commissioner.

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

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

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

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

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

(b) Within 60 days of ending an enrollment moratorium under this section, the commissioner must notify the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services about the results of the moratorium.

Sec. 23. **[256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS FOR SPECIFIC PROVIDER TYPES.**

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

(b) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies medical suppliers meeting the durable medical equipment provider or supplier definition in paragraph (a), operating in Minnesota, and receiving medical assistance money must purchase a surety bond that is annually renewed, designates the state agency as the obligee, and is submitted in a form approved by the commissioner. For purposes of this paragraph, 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.

(c) At the time of initial enrollment or reenrollment, durable medical equipment providers or suppliers as defined in paragraph (a) must purchase a surety bond of $50,000. If a revalidating provider's medical assistance 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 medical assistance 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 be purchased new 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.

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

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

Sec. 24. **[256B.0446] ADDITIONAL PROVIDER ENROLLMENT TRAINING REQUIREMENTS FOR HIGH-RISK PROVIDERS.**

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

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

(b) New owners active in day-to-day management and operations of the agency and new managerial and supervisory employees of the agency must complete compliance training under this subdivision within 30 calendar days of becoming an owner of or beginning employment with the agency and prior to conducting any management or operations activities for the agency. If an individual moves to another agency providing the same service 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 does not repeat the compliance training, the individual must provide documentation to the agency that proves that the individual completed the compliance training within the provider revalidation

schedule for the relevant provider type as determined by the commissioner under section 256B.0441, subdivisions 2 and 3.

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

(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.

Sec. 25. **[256B.0447] ENHANCED PREPAYMENT REVIEW.**

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

Subd. 2. **Review requirement.** Beginning April 1, 2027, the commissioner must conduct enhanced prepayment review under this section of at least 65 percent of all fee-for-service claims.

Subd. 3. **Notice.** (a) Except as provided in paragraph (b), the commissioner must provide written notice to a provider placed under enhanced prepayment review at least 15 days before the review is implemented. The notice must include:

(1) the basis for the review;

(2) the effective date of the review; and

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

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

Subd. 4. **Continued enrollment of new clients.** Nothing in this section prohibits an enrolled provider that is subject to enhanced prepayment review from enrolling new clients

or beneficiaries during the period of review unless otherwise prohibited by law or by a separate action of the commissioner.

Subd. 5. **Timely claims processing.** The commissioner must administer enhanced prepayment review in a manner consistent with Code of Federal Regulations, title 42, section 447.45.

Subd. 6. **Relationship to other actions.** Enhanced prepayment review under this section does not preclude the commissioner from conducting a preliminary investigation, full investigation, payment suspension, postpayment review, audit, overpayment recovery, sanction, or referral to law enforcement under this chapter or under applicable federal law.

Subd. 7. **Information on website.** At least annually, the commissioner must publish information on enhanced prepayment review on the Department of Human Services website. The information must include, at minimum, the list of covered services subject to review and aggregate outcomes, including claim denials, payments delayed, and referrals for further action.

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

Sec. 26. **[256B.0448] POSTPAYMENT REVIEW.**

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

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

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

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

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

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

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

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

Sec. 27. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural. This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

(c) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transportation, within the meaning of "public transportation" as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472, subdivision 1, paragraph (p).

(d) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

(e) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

(f) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services. This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027,~~

~~for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

(g) Effective ~~July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid medical assistance,~~ upon implementation of the administrator under subdivision 18i, the administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care program beneficiaries to obtain covered medical services; and

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode.

(h) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph (n), clauses (4), (5), (6), and (7). This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

(i) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

(j) Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency. This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

(k) Effective ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance,~~ upon implementation of the administrator under subdivision

18i, nonemergency medical transportation providers must take clients to the health care provider using the most direct route and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the administrator.

(l) Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

(m) The administrative agency shall use the level of service process established by the commissioner to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

(n) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety

locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

(o) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph (n) according to paragraphs (r) to (t) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government. This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

(p) The commissioner shall:

(1) verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

(q) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245. This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

(r) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (m), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $12.10 for the base rate and $1.43 per mile when provided by a nonemergency medical transportation provider;

(4) $14.30 for the base rate and $1.43 per mile for assisted transport;

(5) $19.80 for the base rate and $1.70 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary. This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

(s) Effective ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027,~~ upon implementation of the administrator under subdivision 18i, for prepaid medical assistance, payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph (m), not the type of vehicle used to provide the service.

(t) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph (r), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph (r), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph (r), clauses (1) to (7). This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

(u) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs (r) to (t), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies. This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

(v) The commissioner, when determining reimbursement rates for nonemergency medical transportation, shall exempt all modes of transportation listed under paragraph (n) from Minnesota Rules, part 9505.0445, item R, subitem (2).

(w) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (r) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration. This paragraph expires ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under subdivision 18i.

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

Sec. 28. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 18i, is amended to read:

Subd. 18i. **Administration of nonemergency medical transportation.** (a) Effective July 1, 2026, ~~for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance,~~ the commissioner must contract either statewide or regionally for the administration of the nonemergency medical transportation program in compliance with the provisions of this chapter. The contract must include the administration of the nonemergency medical transportation benefit for those enrolled in managed care as described in section 256B.69.

(b) The commissioner must provide six months notice to counties, managed care organizations, and county-based purchasing organizations before implementing the administrator required under this subdivision.

(c) The commissioner must notify the revisor of statutes when the administrator under this subdivision is implemented.

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

Sec. 29. 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.~~ To be eligible for medical assistance reimbursement, an entity must document:

(1) face-to-face contacts between the case manager and the recipient;

(2) telephone contacts between the case manager and the recipient; the recipient's mental health provider or other service providers; the recipient's family members, legal representative, or primary caregiver; or other interested persons;

(3) face-to-face contacts between the case manager and the recipient's mental health provider or other service providers; the recipient's family members, legal representative, or primary caregiver; or other interested persons;

(4) contacts between the case manager and the case manager's clinical supervisor about the recipient;

(5) individual community support plan and assessment development, review, and revision required under section 245.4711, subdivision 4, for an adult, or section 245.4881, subdivision 4, for a child;

(6) travel time spent by the case manager to meet face-to-face with the recipient who resides outside of the county of financial responsibility; and

(7) travel time spent by the case manager within the county of financial responsibility to meet face-to-face with the recipient or the recipient's family, legal representative, or primary caregiver.

(c) For purposes of paragraph (b), clauses (6) and (7), if a case manager arrives on time for a scheduled face-to-face appointment with a recipient or the recipient's family member, legal representative, or primary caregiver and the person fails to keep the appointment, the time spent by the case manager traveling to and from the site of the scheduled appointment is eligible for medical assistance payment. Provider entities must meet all program standards set out in rules governing family community support services as defined in section 245.4871, subdivision 17, and Minnesota Rules, parts 9520.0900 to 9520.0926, and 9505.0322, subpart 9.

~~(c)~~ (d) 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 6. ~~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)~~ (e) 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)~~ (f) 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)~~ (g) 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)~~ (h) 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)~~ (i) 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)~~ (j) 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)~~ (k) 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 section 245.4711, 245.4881, 256B.0924, 256B.094, or 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)~~ (l) 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)~~ (m) 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)~~ (n) Case management services under this subdivision do not include therapy, treatment, legal, or outreach services.

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

~~(p)~~ (q) 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.

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

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

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

(1) suspending payments to an individual or entity;

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

(3) suspending participation in the program;

(4) terminating participation in the program; or

(5) imposing a fine under subdivision 2a.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(i) fraud hotline complaints;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) the computation 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.

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

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

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

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

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

(b) If the commissioner determines that an individual or entity repeatedly violated this chapter, chapter 245G or 254B, or Minnesota Rules, chapter 9505, related to the provision of services to program recipients and the submission of claims for payment, the commissioner may order an individual or entity to forfeit a fine based on the nature, severity, and chronicity of the violations, in an amount of up to $5,000 or 20 percent of the value of the claims, whichever is greater.

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

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

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

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

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

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

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

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

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

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

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

Subd. 2c. **Imposition of withholding or reduction of payments without prior notice.** (a) Except when the commissioner finds good cause not to suspend payments under Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner must

temporarily withhold or reduce payments to an individual or entity without providing advance notice of the withholding or reduction if either of the following occurs:

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

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

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

(1) fraud hotline complaints;

(2) claims data mining;

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

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

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

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

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

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

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

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

(d) The commissioner must immediately cease to withhold or reduce payments under this subdivision and must release the withheld or reduced payments no later than ten days following the earlier of the commissioner's determination that there is insufficient evidence of fraud by the individual or entity, or legal proceedings relating to the alleged fraud are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions.

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

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

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

(b) The costs for the review under paragraph (c) must be borne equally by both parties.

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

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

(e) The commissioner must provide notice to the individual or entity within ten business days of the administrative law judge's completed recommendation. The notice must state that the review process under this subdivision is complete and must include whether the administrative law judge found that the commissioner established there was a credible allegation of fraud.

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

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

Subd. 2e. **Withholding or reduction of payments; review.** If a payment withhold or reduction under subdivision 2c remains in effect after 90 days, the commissioner must submit evidence to an administrative law judge under seal for the administrative law judge to determine whether the commissioner or a law enforcement agency is actively pursuing an investigation under this section. The administrative law judge must review the evidence in camera and provide a recommendation to the commissioner regarding continuing the withholding or reduction. The recommendation of the administrative law judge is advisory and the commissioner's decision to continue a withholding is final and not subject to appeal or reduction. The review under this subdivision must occur every 90 days for each payment withhold or reduction that is in effect. The commissioner must provide a notice to the individual or entity subject to the payment withhold or reduction within ten business days of the completion of each review under this subdivision. The notice must include the administrative law judge's recommendation.

Sec. 39. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision to read:

Subd. 2f. **Judicial review.** The administrative law judge's findings of facts, conclusions of law, and recommendations under subdivisions 2d and 2e are not subject to judicial review.

Sec. 40. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision to read:

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

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

Sec. 41. Minnesota Statutes 2024, section 256B.064, subdivision 3, is amended to read:

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

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

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

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

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

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

(3) other fines or penalties allowed by law.

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

Sec. 42. Minnesota Statutes 2024, section 256B.064, subdivision 4, is amended to read:

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

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

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

Sec. 43. Minnesota Statutes 2024, section 256B.064, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

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

Subd. 8. **Coordination with law enforcement.** When a temporary withholding or reduction of payments under subdivision 2c involves potential criminal conduct, the commissioner must coordinate with appropriate law enforcement authorities, including the Minnesota attorney general's Medicaid Fraud Control Unit, and may consult with state or federal investigative agencies as necessary.

Sec. 46. **[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.

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

Sec. 47. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, as amended by Laws 2026, chapter 95, article 4, section 15, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 48. 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 section 245.4711; 245.4881; 256B.0625, subdivisions 20 and 20b; 256B.0924; 256B.094; or 256F.10. The county of financial responsibility, as determined under chapter 256G 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. 49. 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 in the joint governance agreement 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 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) To appeal a final rate determined by the commissioner under paragraph (b), a county must submit a written appeal request to the commissioner within 60 days after the date the commissioner issued the final rate determination. The appeal request must specify the disputed items and 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 medical assistance costs. The county of financial responsibility, as determined under chapter 256G, 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 targeted 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. 50. 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. The joint governance agreement must:

(1) establish system functionality requirements to (i) meet the business needs of local agencies providing targeted case management services and (ii) comply with applicable state and federal regulations for the Social Services Information System (SSIS), SSIS's replacement, and adjacent systems and the targeted 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 a required testing period of 12 calendar months and the express approval by the commissioners of human services and children, youth, and families; AMC; and MACSSA.

Sec. 51. 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 section 256L.03, subdivisions 1a and 1b, 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.

Sec. 52. 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.

Sec. 53. Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, as amended by Laws 2026, chapter 88, article 1, section 126, and Laws 2026, chapter 95, article 4, section 21, 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~~ 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. Payment for case management provided by vendors who contract with a Tribe must be made in accordance with Indian Health Service facility requirements. If a Tribe chooses to contract with a vendor receiving payment not through an Indian Health Service facility, the rate must be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged by the vendor for the same service to other payers. If the service is provided by a team of contracted vendors, the team shall determine how to distribute the rate among its members. No reimbursement received by contracted vendors shall be returned to the county or Tribe, except to reimburse the county or Tribe for advance funding provided by the county or Tribe to the vendor.

(d) If the service is provided by a team that includes any combination of contracted vendors, county staff, and Tribal staff, the costs for county staff participation on the team shall be included in the rate for county-provided services. In this case, the contracted vendor and the county and Tribal case managers may each receive separate payment for services provided by each entity in the same month. In order to prevent duplication of services, each

entity must document the need for team targeted case management and a description of the different roles of staff.

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

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

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

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

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

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

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

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

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

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

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

Sec. 54. 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. 55. 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. 56. 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.

~~(e)~~ (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. 57. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, as amended by Laws 2026, chapter 95, article 4, section 24, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 58. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

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

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

(1) EIDBI provider qualifications under this section;

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

(3) EIDBI provider or agency standards or requirements.

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

Sec. 59. Minnesota Statutes 2024, section 256B.69, subdivision 5a, is amended to read:

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

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

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each

performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 60. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision to read:

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

Sec. 61. Minnesota Statutes 2024, section 256B.69, subdivision 37, is amended to read:

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

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

(c) For purposes of this subdivision, "network provider" means any provider, group of providers, entity with a network provider agreement with the managed care organization, or subcontractor that receives payments from the managed care organization either directly or indirectly to provide services under a managed care contract between the commissioner and the managed care organization.

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

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

Sec. 62. Laws 2025, First Special Session chapter 3, article 8, section 43, the effective date, is amended to read:

EFFECTIVE DATE. Paragraph (b) is effective ~~July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance~~ upon implementation of the administrator under Minnesota Statutes, section 256B.0625, subdivision 18i. The commissioner of human services must notify the revisor of statutes when the administrator under Minnesota Statutes, section 256B.0625, subdivision 18i, is implemented. Paragraph (c) is effective on the latest of the following: (1) January 1, 2026; (2) federal approval of the medical assistance program changes in this section; (3) federal approval of the amendments in this act to Minnesota Statutes, section 256B.76, subdivision 6; (4) federal approval of the amendments in this act to Minnesota Statutes, section 256B.761; or (5) federal approval of all necessary federal waivers to implement the managed care organization assessment in Minnesota Statutes, section 295.525. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Sec. 63. **MANDATORY COMPLIANCE TRAINING FOR CURRENTLY ENROLLED HIGH-RISK MEDICAL ASSISTANCE PROVIDERS.**

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

Sec. 64. **REPEALER.**

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

ARTICLE 4
DEPARTMENT OF HUMAN SERVICES OIG POLICY

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

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

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

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

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

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

(1) fraud hotline complaints;

(2) claims data mining;

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

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

(5) information from the inspector general appointed under chapter 15E, including information listed on the inspector general's exclusion list under section 15E.25, subdivision 1, clause (11).

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

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

(1) a final determination to stop payments~~.~~;

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

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

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

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

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

Sec. 2. Minnesota Statutes 2024, section 245.095, subdivision 5, as amended by Laws 2026, chapter 92, article 2, section 12, is amended to read:

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

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

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

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

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

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

~~(1) fraud hotline complaints;~~

~~(2) claims data mining;~~

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

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

~~(5) information from the inspector general appointed under chapter 15E, including information listed on the inspector general's exclusion list under section 15E.25, subdivision 1, clause (11).~~

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. 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;

(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.

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

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

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

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

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

(2) the license holder merges with another organization;

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

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

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

~~(b) For changes under paragraph (a), clause (1) or (5), no change in ownership has occurred and a new license application is not required if at least one controlling individual~~

~~has been affiliated as a controlling individual for the license for at least the previous 12 months immediately preceding the change.~~

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

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

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

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

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

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

Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the burden of proof in expedited hearings under this subdivision ~~shall be limited to~~ is met only if the ~~commissioner's demonstration~~ commissioner demonstrates that reasonable cause exists to believe that the license holder's or controlling individual's actions or failure to comply with applicable law or rule poses, or the actions of other individuals or conditions in the program poses an imminent risk of harm to the health, safety, or rights of persons served by the program. "Reasonable cause" means there exist specific articulable facts or circumstances which provide the commissioner with a reasonable suspicion that there is an imminent risk of harm to the health, safety, or rights of persons served by the program.

When the commissioner has determined there is reasonable cause to order the temporary immediate suspension of a license based on a violation of safe sleep requirements, as defined in section 245A.1435, the commissioner is not required to demonstrate that an infant died or was injured as a result of the safe sleep violations. For suspensions under subdivision 2, paragraph (a), clause (2), the burden of proof in expedited hearings under this subdivision ~~shall be limited to~~ is met only if the ~~commissioner's demonstration~~ commissioner demonstrates by a preponderance of the evidence that, since the license was revoked, the license holder committed additional violations of law or rule which may adversely affect the health or safety of persons served by the program.

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

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

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

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

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

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

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

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

Sec. 8. 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) or (3).

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 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 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. 9. 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~~ must 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 or equal to $20,000,000	$32,000
greater than $20,000,000 but less than or equal to $25,000,000	$36,000
greater than $25,000,000 but less than or equal to $30,000,000	$45,000
greater than $30,000,000 but less than or equal to $35,000,000	$55,000
greater than $35,000,000	$75,000

(2) If requested, the license holder ~~shall~~ must 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~~ must 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~~ must 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~~ must 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~~ must 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~~ must 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~~ must 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~~ must 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~~ must pay an annual nonrefundable license fee of $20,000.

(i) A mental health clinic certified under section 245I.20 ~~shall~~ must pay an annual nonrefundable certification fee of $1,550. If the mental health clinic provides services at a primary location with satellite facilities, the satellite facilities ~~shall~~ must 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.

Sec. 10. Minnesota Statutes 2025 Supplement, section 245A.142, subdivision 3, is amended to read:

Subd. 3. **Provisional license.** (a) Beginning January 1, 2026, the commissioner ~~shall~~ must begin issuing provisional licenses to agencies enrolled under chapter 256B to provide EIDBI services.

(b) Agencies enrolled before July 1, 2025, have until May 31, 2026, to submit an application for provisional licensure on the forms and in the manner prescribed by the commissioner.

(c) Beginning June 1, 2026, an agency must not operate if it has not submitted an application for provisional licensure under this section. The commissioner shall disenroll an agency from providing EIDBI services under chapter 256B if the agency fails to submit an application for provisional licensure by May 31, 2026.

(d) The commissioner must determine whether a provisional license applicant complies with all applicable rules and laws and either issue a provisional license to the applicant or deny the application by December 31, 2026.

(e) A provisional license is effective until comprehensive EIDBI agency licensure standards are in effect unless the provisional license is suspended or revoked.

(f) Initial provisional license applications are subject to the application fee under section 245A.10, subdivision 3, paragraph (a).

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

Sec. 11. Minnesota Statutes 2025 Supplement, section 245A.242, subdivision 2, is amended to read:

Subd. 2. **Emergency overdose treatment.** (a) A license holder must maintain a supply of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency treatment of opioid overdose ~~and~~. For administration via intramuscular injection, a license holder must have a written standing order protocol by a physician who is licensed under chapter 147, advanced practice registered nurse who is licensed under chapter 148, or physician assistant who is licensed under chapter 147A, that permits the license holder to maintain a supply of intramuscular injection opiate antagonists on site. A license holder must require staff to undergo training in the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both, before the staff has direct contact, as defined in section 245C.02, subdivision 11, with a person served by the program.

(b) Notwithstanding any requirements to the contrary in Minnesota Rules, chapters 2960 and 9530, and Minnesota Statutes, chapters 245F, 245G, and 245I:

(1) emergency opiate antagonist medications are not required to be stored in a locked area and staff and adult clients may carry this medication on them and store it in an unlocked location;

(2) staff persons who only administer emergency opiate antagonist medications only require the training required by paragraph (a), which any knowledgeable trainer may provide. The trainer is not required to be a registered nurse or part of an accredited educational institution; and

(3) nonresidential substance use disorder treatment programs that do not administer client medications beyond emergency opiate antagonist medications are not required to have the policies and procedures required in section 245G.08, subdivisions 5 and 6, and must instead describe the program's procedures for administering opiate antagonist medications in the license holder's description of health care services under section 245G.08, subdivision 1.

Sec. 12. Minnesota Statutes 2024, section 245C.02, subdivision 18, is amended to read:

Subd. 18. **Serious maltreatment.** (a) "Serious maltreatment" means sexual abuse, maltreatment resulting in death, neglect resulting in serious injury which reasonably requires the care of a physician, advanced practice registered nurse, or physician assistant whether or not the care of a physician, advanced practice registered nurse, or physician assistant was sought, ~~or~~ abuse resulting in serious injury, or financial exploitation of a vulnerable adult if the value of the funds or property is $1,000 or greater.

(b) For purposes of this definition, "care of a physician, advanced practice registered nurse, or physician assistant" is treatment received or ordered by a physician, physician assistant, or advanced practice registered nurse, but does not include:

(1) diagnostic testing, assessment, or observation;

(2) the application of, recommendation to use, or prescription solely for a remedy that is available over the counter without a prescription; or

(3) a prescription solely for a topical antibiotic to treat burns when there is no follow-up appointment.

(c) For purposes of this definition, "abuse resulting in serious injury" means: bruises, bites, skin laceration, or tissue damage; fractures; dislocations; evidence of internal injuries; head injuries with loss of consciousness; extensive second-degree or third-degree burns and other burns for which complications are present; extensive second-degree or third-degree frostbite and other frostbite for which complications are present; irreversible mobility or avulsion of teeth; injuries to the eyes; ingestion of foreign substances and objects that are harmful; near drowning; and heat exhaustion or sunstroke.

(d) Serious maltreatment includes neglect when it results in criminal sexual conduct against a child or vulnerable adult.

Sec. 13. 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~~.~~; and

(13) children's foster residence settings.

EFFECTIVE DATE. This section is effective November 3, 2026.

Sec. 14. Minnesota Statutes 2024, section 245C.04, subdivision 1, is amended to read:

Subdivision 1. **Licensed programs; other child care programs.** (a) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, at least upon application for initial license for all license types.

(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)~~ (e) 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, or currently affiliated without a background study that was submitted through the electronic system known as NETStudy 2.0, 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)~~ (f) 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, or currently affiliated without a background study that was submitted through the electronic system known as NETStudy 2.0, 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)~~ (g) 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 2.0 before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

~~(i)~~ (h) 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)~~ (i) 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)~~ (j) For purposes of family child care, a substitute caregiver must receive repeat background studies at the time of each license renewal.

~~(l)~~ (k) 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)~~ (l) 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. 15. Minnesota Statutes 2025 Supplement, section 245C.07, is amended to read:

245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.

(a) Subject to the conditions in paragraph (d), when a license holder, applicant, or other entity owns multiple programs or services that are licensed by the Department of Human Services; Department of Children, Youth, and Families; Department of Health; or Department of Corrections, only one background study is required for an individual who provides direct contact services in one or more of the licensed programs or services if:

(1) the license holder designates one individual with one address and telephone number as the person to receive sensitive background study information for the multiple licensed programs or services that depend on the same background study; and

(2) the individual designated to receive the sensitive background study information is capable of determining, upon request of the department, whether a background study subject is providing direct contact services in one or more of the license holder's programs or services and, if so, at which location or locations.

(b) When a license holder maintains background study compliance for multiple licensed programs according to paragraph (a), and one or more of the licensed programs closes, the license holder shall immediately notify the commissioner which staff must be transferred to an active license so that the background studies can be electronically paired with the license holder's active program.

(c) When a background study is being initiated by a licensed program or service or a foster care provider that is also licensed under chapter 144G, a study subject affiliated with multiple licensed programs or services may attach to the background study form a cover letter indicating the additional names of the programs or services, addresses, and background study identification numbers.

When the commissioner receives a notice, the commissioner shall notify each program or service identified by the background study subject of the study results.

The background study notice the commissioner sends to the subsequent agencies shall satisfy those programs' or services' responsibilities for initiating a background study on that individual.

(d) ~~If a background study was conducted on an individual related to child foster care and the requirements under paragraph (a) are met, the background study is transferable across all licensed programs.~~ If a background study was conducted on an individual under a license other than child foster care and the requirements under paragraph (a) are met, the background study is transferable to all licensed programs except child foster care.

(e) The provisions of this section that allow a single background study in one or more licensed programs or services do not apply to background studies submitted by adoption agencies, supplemental nursing services agencies, personnel pool agencies, educational programs, professional services agencies, temporary personnel agencies, and unlicensed personal care provider organizations.

(f) For an entity operating under NETStudy 2.0, the entity's active roster must be the system used to document when a background study subject is affiliated with multiple entities. For a background study to be transferable:

(1) the background study subject must be on and moving to a roster for which the person designated to receive sensitive background study information is the same; and

(2) the same entity must own or legally control both the roster from which the transfer is occurring and the roster to which the transfer is occurring. For an entity that holds or controls multiple licenses, or unlicensed personal care provider organizations, there must be a common highest level entity that has a legally identifiable structure that can be verified through records available from the secretary of state.

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

Sec. 16. 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 child care background study ~~affiliated with a licensed child care center or certified license-exempt child care center~~ subject required to submit fingerprints for a national criminal history check, except as provided in section 245C.05, subdivision 5a, 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~~ a child care background study subject, ~~providing direct contact services to persons served by the program~~ performing any act listed in section 245C.02, subdivision 6a, unless the study is being renewed under section 245C.04, subdivision 1, paragraph (b), and it has been less than five years since the child care background study subject was previously disqualified or provided notice under paragraph (a), clause (1), item (i);

(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, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study of the personal care assistant under this chapter and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant 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.

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

Sec. 17. Minnesota Statutes 2024, section 245C.15, subdivision 2, is amended to read:

Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a felony-level violation of any of the following offenses: sections 152.021, subdivision 1 or 2b, (aggravated controlled substance

crime in the first degree; sale crimes); 152.022, subdivision 1 (controlled substance crime in the second degree; sale crimes); 152.023, subdivision 1 (controlled substance crime in the third degree; sale crimes); 152.024, subdivision 1 (controlled substance crime in the fourth degree; sale crimes); 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 518B.01, subdivision 14 (violation of an order for protection); 609.165 (felon ineligible to possess firearm); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.223 or 609.2231 (assault in the third or fourth degree); repeat offenses under 609.224 (assault in the fifth degree); 609.229 (crimes committed for benefit of a gang); 609.2325 (criminal abuse of a vulnerable adult); 609.2334 (violation of an order for protection against financial exploitation of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.235 (use of drugs to injure or facilitate crime); 609.24 (simple robbery); 609.247, subdivision 4 (carjacking in the third degree); 609.255 (false imprisonment); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.27 (coercion); 609.275 (attempt to coerce); 609.466 (medical assistance fraud); 609.495 (aiding an offender); 609.498, subdivision 1 or 1b (aggravated first-degree or first-degree tampering with a witness); 609.52 (theft); 609.521 (possession of shoplifting gear); 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.542 (illegal remunerations); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.625 (aggravated forgery); 609.63 (forgery); 609.631 (check forgery; offering a forged check); 609.635 (obtaining signature by false pretense); 609.66 (dangerous weapons); 609.67 (machine guns and short-barreled shotguns); 609.687 (adulteration); 609.71 (riot); 609.713 (terroristic threats); 609.746 (interference with privacy); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; repeat offenses under 617.241 (obscene materials and performances; distribution and exhibition prohibited; penalty); or 624.713 (certain persons not to possess firearms).

(b) An individual is disqualified under section 245C.14 if less than 15 years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245C.14 if less than 15 years has passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or subdivision 3.

(d) An individual is disqualified under section 245C.14 if less than 15 years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of the offenses listed in paragraph (a) or since the termination of parental rights in any other state or country, the elements of which are substantially similar to the elements listed in paragraph (c).

(e) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a gross misdemeanor or misdemeanor, the individual is disqualified but the disqualification look-back period for the offense is the period applicable to the gross misdemeanor or misdemeanor disposition.

(f) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Sec. 18. Minnesota Statutes 2024, section 245C.15, subdivision 3, is amended to read:

Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a gross misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 260B.425 (criminal jurisdiction for contributing to status as a juvenile petty offender or delinquency); 260C.425 (criminal jurisdiction for contributing to need for protection or services); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth degree); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal

neglect of a vulnerable adult); 609.2334 (violation of an order for protection against financial exploitation of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft); 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631 (check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); 609.746 (interference with privacy); 609.749, subdivision 2 (harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01, subdivision 14.

(b) An individual is disqualified under section 245C.14 if less than ten years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraph (a), as each of these offenses is defined in Minnesota Statutes.

(c) An individual is disqualified under section 245C.14 if less than ten years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraph (a).

(d) If the individual studied commits one of the offenses listed in paragraph (a), but the sentence or level of offense is a misdemeanor disposition, the individual is disqualified but the disqualification lookback period for the offense is the period applicable to misdemeanors.

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

Sec. 19. Minnesota Statutes 2024, section 245C.15, subdivision 4, is amended to read:

Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 260B.425 (criminal jurisdiction for contributing to status as a juvenile petty offender or delinquency); 260C.425 (criminal jurisdiction for contributing to need for protection or services); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231 (assault in the fourth degree); 609.224 (assault in the fifth degree); 609.2242 (domestic assault); 609.2334 (violation of an order for protection against financial exploitation of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree); 609.27 (coercion); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft); 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter, telegram, or package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01 (Domestic Abuse Act).

(b) An individual is disqualified under section 245C.14 if less than seven years has passed since a determination or disposition of the individual's:

(1) failure to make required reports under section 260E.06 or 626.557, subdivision 3, for incidents in which: (i) the final disposition under section 626.557 or chapter 260E was substantiated maltreatment, and (ii) the maltreatment was recurring or serious; or

(2) substantiated serious or recurring maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under section 626.557 or chapter 260E for which: (i) there is a preponderance of evidence that the maltreatment occurred, and (ii) the subject was responsible for the maltreatment.

(c) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes.

(d) An individual is disqualified under section 245C.14 if less than seven years has passed since the discharge of the sentence imposed for an offense in any other state or country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraphs (a) and (b).

(e) When a disqualification is based on a judicial determination other than a conviction, the disqualification period begins from the date of the court order. When a disqualification is based on an admission, the disqualification period begins from the date of an admission in court. When a disqualification is based on an Alford Plea, the disqualification period begins from the date the Alford Plea is entered in court. When a disqualification is based on a preponderance of evidence of a disqualifying act, the disqualification date begins from the date of the dismissal, the date of discharge of the sentence imposed for a conviction for a disqualifying crime of similar elements, or the date of the incident, whichever occurs last.

(f) An individual is disqualified under section 245C.14 if less than seven years has passed since the individual was disqualified under section 256.98, subdivision 8.

Sec. 20. Minnesota Statutes 2025 Supplement, section 245C.15, subdivision 4a, is amended to read:

Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated with a licensed family foster setting, regardless of how much time has passed, an individual is disqualified under section 245C.14 if the individual committed an act that resulted in a felony-level conviction for sections: 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse); 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245 (aggravated robbery); 609.247, subdivision 2 or 3 (carjacking in the first or second degree); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661

(murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and promotion of prostitution; sex trafficking in the first degree); 609.324, subdivision 1 (other prohibited acts; engaging in, hiring, or agreeing to hire minor to engage in prostitution); 609.342 (criminal sexual conduct in the first degree); 609.343 (criminal sexual conduct in the second degree); 609.344 (criminal sexual conduct in the third degree); 609.345 (criminal sexual conduct in the fourth degree); 609.3451 (criminal sexual conduct in the fifth degree); 609.3453 (criminal sexual predatory conduct); 609.3458 (sexual extortion); 609.352 (solicitation of children to engage in sexual conduct); 609.377 (malicious punishment of a child); 609.3775 (child torture); 609.378 (neglect or endangerment of a child); 609.561 (arson in the first degree); 609.582, subdivision 1 (burglary in the first degree); 609.746 (interference with privacy); 617.23 (indecent exposure); 617.246 (use of minors in sexual performance prohibited); or 617.247 (possession of child sexual abuse material).

(b) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for the purposes of a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14, regardless of how much time has passed, if the individual:

(1) committed an action under paragraph (e) that resulted in death or involved sexual abuse, as defined in section 260E.03, subdivision 20;

(2) committed an act that resulted in a gross misdemeanor-level conviction for section 609.3451 (criminal sexual conduct in the fifth degree);

(3) committed an act against or involving a minor that resulted in a felony-level conviction for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree); or

(4) committed an act that resulted in a misdemeanor or gross misdemeanor-level conviction for section 617.293 (dissemination and display of harmful materials to minors).

(c) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if fewer than 20 years have passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or if the individual consented to a

termination of parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to involuntarily terminate parental rights. An individual is disqualified under section 245C.14 if fewer than 20 years have passed since the termination of the individual's parental rights in any other state or country, where the conditions for the individual's termination of parental rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph (b).

(d) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if fewer than five years have passed since a felony-level violation for sections: 152.021 (controlled substance crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing controlled substances across state borders); 152.0262, subdivision 1, paragraph (b) (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities); 152.137 (fentanyl- and methamphetamine-related crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while impaired); 243.166 (violation of predatory offender registration requirements); 609.2113 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery); 609.247, subdivision 4 (carjacking in the third degree); 609.322, subdivision 1a (solicitation, inducement, and promotion of prostitution; sex trafficking in the second degree); 609.498, subdivision 1 (tampering with a witness in the first degree); 609.498, subdivision 1b (aggravated first-degree witness tampering); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582, subdivision 2 (burglary in the second degree); 609.66 (felony dangerous weapons); 609.687 (adulteration); 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or 624.713 (certain people not to possess firearms).

(e) Notwithstanding subdivisions 1 to 4, 4b, and 4c, except as provided in paragraph (a), for a background study affiliated with a licensed family child foster care license, an individual is disqualified under section 245C.14 if fewer than five years have passed since:

(1) a felony-level violation for an act not against or involving a minor that constitutes: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the fifth degree);

(2) a violation of an order for protection under section 518B.01, subdivision 14;

(3) a determination or disposition of the individual's failure to make required reports under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment was recurring or serious;

(4) a determination or disposition of the individual's substantiated serious or recurring maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under chapter 260E or section 626.557 and meet the definition of serious maltreatment or recurring maltreatment;

(5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

(6) committing an act against or involving a minor that resulted in a misdemeanor-level violation of section 609.224, subdivision 1 (assault in the fifth degree).

(f) For purposes of this subdivision, the disqualification begins from:

(1) the date of the alleged violation, if the individual was not convicted;

(2) the date of conviction, if the individual was convicted of the violation but not committed to the custody of the commissioner of corrections; or

(3) the date of release from prison, if the individual was convicted of the violation and committed to the custody of the commissioner of corrections.

Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation of the individual's supervised release, the disqualification begins from the date of release from the subsequent incarceration.

(g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245C.14. An individual is

disqualified under section 245C.14 if fewer than five years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (d) and (e).

(h) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraphs (a) and (b), permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if fewer than five years have passed since an offense in any other state or country, the elements of which are substantially similar to the elements of any offense listed in paragraphs (d) and (e).

Sec. 21. 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)~~ (g), 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. 22. 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)~~ (f), 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. 23. Minnesota Statutes 2024, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.061 or successor provisions; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8, or successor provisions;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the website, email, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice in the community;

(14) personal privacy, including the right to use the lock on the person's bedroom or unit door;

(15) engage in chosen activities; and

(16) access to the person's personal possessions at any time, including financial resources.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will;

(4) choose the person's visitors and time of visits and have privacy for visits with the person's spouse, next of kin, legal counsel, religious adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom;

(5) have access to three nutritionally balanced meals and nutritious snacks between meals each day;

(6) have freedom and support to access food and potable water at any time;

(7) have the freedom to furnish and decorate the person's bedroom or living unit;

(8) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling paint, mold, vermin, and insects;

(9) a setting that is free from hazards that threaten the person's health or safety; and

(10) a setting that meets the definition of a dwelling unit within a residential occupancy as defined in the State Fire Code.

(c) Restriction of a person's rights under paragraph (a), clauses (13) to (16), or paragraph (b), clauses (1) to (7), is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's support plan or support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support

to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

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

Sec. 24. Minnesota Statutes 2024, section 245D.10, subdivision 4, is amended to read:

Subd. 4. **Availability of current written policies and procedures.** (a) The license holder must review and update, as needed, the written policies and procedures required under this chapter.

(b)(1) The license holder must inform the person, the person's legal representative, and the person's case manager of the policies and procedures affecting a person's rights under section 245D.04, and provide copies of those policies and procedures, within five working days of service initiation.

(2) If a license holder only provides basic services and supports, this includes the:

(i) grievance policy and procedure required under subdivision 2; ~~and~~

(ii) service suspension and termination policy and procedure required under subdivision 3.~~;~~ and

(iii) emergency use of manual restraints policy and procedure required under section 245D.061, subdivision 9, or successor provisions.

(3) For all other license holders this includes the:

(i) policies and procedures in clause (2); and

~~(ii) emergency use of manual restraints policy and procedure required under section 245D.061, subdivision 9, or successor provisions; and~~

~~(iii)~~ (ii) data privacy requirements under section 245D.11, subdivision 3.

(c) The license holder must provide a written notice to all persons or their legal representatives and case managers at least 30 days before implementing any procedural revisions to policies affecting a person's service-related or protection-related rights under section 245D.04 and maltreatment reporting policies and procedures. The notice must explain the revision that was made and include a copy of the revised policy and procedure. The license holder must document the reasonable cause for not providing the notice at least 30 days before implementing the revisions.

(d) Before implementing revisions to required policies and procedures, the license holder must inform all employees of the revisions and provide training on implementation of the revised policies and procedures.

(e) The license holder must annually notify all persons, or their legal representatives, and case managers of any procedural revisions to policies required under this chapter, other than those in paragraph (c). Upon request, the license holder must provide the person, or the person's legal representative, and case manager with copies of the revised policies and procedures.

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

Sec. 25. Minnesota Statutes 2024, section 256B.02, is amended by adding a subdivision to read:

Subd. 20. **Fraud.** "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to the person or another person or an act, promise to act, or omission made with the intent to obtain a benefit in a manner that is prohibited. Fraud includes:

(1) submitting an application for provider status knowing that the application misrepresents, conceals, or fails to disclose any material information;

(2) intentionally submitting a claim for reimbursement under this chapter, knowing or having reason to know the claim is ineligible for reimbursement in whole or in part;

(3) providing documentation or other information requested by the commissioner having knowledge that it is false in any material respect; and

(4) any act that constitutes the commission, or attempt or conspiracy to commit, a violation of any of the following:

(i) section 256.98 (wrongfully obtaining assistance);

(ii) section 609.466 (medical assistance fraud);

(iii) section 609.48 (perjury), involving making a false statement related to medical assistance or the receipt of public money;

(iv) section 609.496 (concealing criminal proceeds) or 609.497 (engaging in business of concealing criminal proceeds), involving proceeds consisting of public money;

(v) section 609.52 (theft), involving theft of property consisting of public money;

(vi) section 609.542 (illegal remuneration);

(vii) section 609.625 (aggravated forgery) or 609.63 (forgery), involving falsely filing any record, account, or other document with any state agency or department or falsely making or altering any record, account, or other document filed with any state agency or department;

(viii) section 609.821 (financial transaction card fraud), involving a public assistance benefit;

(ix) a felony listed in United States Code, title 42, section 1320a-7b(b)(1) or (2), subject to any safe harbors established in Code of Federal Regulations, title 42, section 1001.952; and

(x) any other act that constitutes fraud under applicable federal law.

Sec. 26. Minnesota Statutes 2024, section 256B.04, subdivision 10, is amended to read:

Subd. 10. **Investigation of certain claims.** The commissioner must establish by rule general criteria and procedures for the identification and prompt investigation of suspected medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not reasonable or medically necessary, or false statement or representation of material facts by a vendor of medical care~~, and for the imposition of sanctions against a vendor of medical care~~. The commissioner may use both prepayment and postpayment review systems to review claims submitted by vendors. Payment of claims, including payments made after a prepayment review, does not prohibit the commissioner from completing a postpayment claims review and taking additional administrative actions or monetary recovery against a vendor. If it appears to the state agency that a vendor of

medical care may have acted in a manner warranting civil or criminal proceedings, it shall so inform the attorney general in writing.

Sec. 27. Minnesota Statutes 2025 Supplement, section 256B.0659, subdivision 21, is amended to read:

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

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

(2) proof of surety bond coverage for each business location providing services. Upon new enrollment, or if the 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 the Medicaid 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~~ purchased new 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;

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

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

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

(6) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

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

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

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

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

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

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

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

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

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

(13) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

(b) Personal care assistance provider agencies shall provide the information specified in paragraph (a) to the commissioner at the time the personal care assistance provider agency

enrolls as a vendor or upon request from the commissioner. The commissioner shall collect the information specified in paragraph (a) from all personal care assistance providers beginning July 1, 2009.

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

(d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability insurance required by this subdivision must be maintained continuously and purchased new annually. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

Sec. 28. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is amended to read:

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

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

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

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

(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~~ purchased new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

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

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

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

Sec. 29. Minnesota Statutes 2024, section 256B.27, subdivision 3, is amended to read:

Subd. 3. **Access to medical records.** The commissioner of human services, with the written consent of the recipient, on file with the local welfare agency, shall be allowed access in the manner and within the time prescribed by the commissioner to all personal

medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or (b) the medical care was medically necessary. ~~When the commissioner is investigating a possible overpayment of Medicaid funds,~~ The commissioner may conduct on-site inspections of any and all vendors and service locations or may request records from a vendor to verify that information submitted to the commissioner is accurate, determine compliance with service delivery and billing requirements, and determine compliance with any other applicable laws or rules. The commissioner must be given immediate access without prior notice to the vendor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. The department shall document in writing the need for immediate access to records related to a specific investigation. Denying the commissioner access to records is cause for the vendor's immediate suspension of payment or termination according to section 256B.064. The determination of provision of services not medically necessary shall be made by the commissioner. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to this section.

Sec. 30. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 12, is amended to read:

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

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

(2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the agency-provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be ~~renewed~~ purchased new 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;

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 31. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 17a, is amended to read:

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

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

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

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

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

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the consultation service provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be ~~renewed~~ purchased new 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) employ lead professional staff with a minimum of two years of experience in providing services such as support planning, support broker, case management or care coordination, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

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

(8) comply with medical assistance provider requirements;

(9) understand the CFSS program and its policies;

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

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

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

Sec. 32. Minnesota Statutes 2025 Supplement, section 260E.03, subdivision 6, is amended to read:

Subd. 6. **Facility.** "Facility" means:

(1) a licensed or unlicensed day care facility, certified license-exempt child care center, residential facility, agency, psychiatric residential treatment facility, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 142B, 142C, 144H, or 245D;

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

(3) a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a.

Sec. 33. Minnesota Statutes 2025 Supplement, section 260E.11, subdivision 1, is amended to read:

Subdivision 1. **Reports of maltreatment in facility.** A person mandated to report child maltreatment occurring within a licensed facility ~~shall~~ must report the information to the agency responsible for licensing or certifying the facility under sections 144.50 to 144.58, 241.021, and 245A.01 to 245A.16 or chapter 142B, 142C, 144H, or 245D or to a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a. A person mandated to report child maltreatment occurring within a federally certified psychiatric residential treatment facility must report the information to the Department of Health.

Sec. 34. 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, except federally certified psychiatric residential treatment facilities.

(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, or federally certified as a psychiatric residential treatment facility.

(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.

Sec. 35. 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, federally certified psychiatric residential treatment facilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community

residential settings, programs for people with disabilities, EIDBI agencies, family adult day services, mental health programs, mental health clinics, substance use disorder programs, the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services, except federally certified psychiatric residential treatment facilities. The Department of Human Services is also the lead investigative agency for unlicensed EIDBI agencies under section 256B.0949.

(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.

Sec. 36. **NEW BACKGROUND STUDIES FOR INDIVIDUALS NOT IN NETSTUDY 2.0.**

By March 1, 2027, the commissioner of human services and counties must conduct new background studies for all individuals specified under Minnesota Statutes, section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), and affiliated with a child foster family setting license holder, 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 Minnesota Statutes, chapter 142E. The commissioner and counties must follow the requirements in Minnesota Statutes, section 245C.04, subdivision 1, paragraphs (e) and (f), when conducting the background studies under this section. The new background studies must be submitted through NETStudy 2.0.

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

Sec. 37. **REPEALER.**

(a) Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3a, is repealed.

(b) Minnesota Rules, part 9505.2165, subpart 4, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective October 1, 2026.

ARTICLE 5
BACKGROUND STUDIES

Section 1. 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, family adult day services, or adult foster care studies.

EFFECTIVE DATE. This section is effective January 25, 2028.

Sec. 2. Minnesota Statutes 2024, section 245C.03, subdivision 3a, is amended to read:

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, board members, 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 employee and volunteer qualified professionals.

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

Sec. 3. 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, board members, 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~~ employees or volunteers 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 employee and volunteer support workers.

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

Sec. 4. 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 must conduct background studies on any individual who is an owner 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. For purposes of this subdivision, operator includes board members or other individuals who oversee the billing, management, or policies of the services provided.

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

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

Subd. 18. **Providers of peer recovery support services.** The commissioner shall conduct background studies on any individual who is an owner with an ownership stake of at least five percent in a peer recovery support services provider or an operator of a peer recovery support services provider under section 254B.052. For the purposes of this subdivision, "operator" includes board members or other individuals who oversee the billing, management, or policies of the services provided.

EFFECTIVE DATE. This section is effective upon implementation in NETStudy 2.0, but no sooner than December 15, 2026.

Sec. 6. 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 must conduct background studies on any individual who is an owner 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. For purposes of this subdivision, "operator" includes board members or other individuals who oversee the billing, management, or policies of the services provided.

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

Sec. 7. 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, family 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. 8. 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.~~

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

Sec. 9. 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.

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

ARTICLE 6
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 or Tribe 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.

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

Subd. 3a. **Authority and rulemaking.** (a) The commissioner may distribute money under this section through direct payments to counties or Tribes 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.

(b) By January 1, 2027, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy that includes, at a minimum, the commissioner's plan for determining direct payment eligibility criteria, allowable uses of direct payments, documentation standards, and reporting requirements for recipients of direct payments.

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 money 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.

(f) By January 1, 2027, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services finance and policy that, at a minimum, describes the commissioner's development of the monitoring, financial review, and accountability procedures as required under this section.

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

Sec. 6. 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. 7. 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. 8. 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. 9. Minnesota Statutes 2025 Supplement, section 254B.0505, is amended by adding a subdivision to read:

Subd. 9. **Billing limits.** Treatment coordination must not exceed five hours per week per recipient.

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

Sec. 10. 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~~ section 254B.0505, subdivision 1, clauses (1) to (9), 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. 11. Minnesota Statutes 2024, section 254B.17, is amended to read:

254B.17 WITHDRAWAL MANAGEMENT START-UP AND CAPACITY-BUILDING GRANTS.

The commissioner must establish start-up and capacity-building grants for prospective ~~or,~~ new, or existing substance use disorder treatment or withdrawal management programs ~~licensed under chapter 245F~~ that will meet ASAM criteria for medically ~~monitored~~ managed or clinically monitored levels of care by integrating withdrawal management services into outpatient, intensive outpatient, or residential treatment services. Grants must be used to measurably increase client capacity or expand available services and must align services with ASAM criteria. Grants may be used to add medications for opioid use disorder to a grantee's available services and for capacity-building expenses that are not reimbursable under Minnesota health care programs, including but not limited to:

(1) costs associated with hiring staff or contracting with medical services providers;

(2) costs associated with staff retention;

(3) the purchase of office equipment and supplies;

(4) the purchase of software;

(5) costs associated with obtaining applicable and required licenses;

(6) business formation costs;

(7) costs associated with staff training; ~~and~~

(8) the purchase of medical equipment and supplies necessary to meet health and safety requirements~~.~~;

(9) costs associated with adding or improving physical space;

(10) start-up costs associated with adding new locations; and

(11) costs associated with becoming ASAM certified for medically managed levels of care.

Sec. 12. Minnesota Statutes 2024, section 256B.04, subdivision 23, is amended to read:

Subd. 23. **Medical assistance costs for certain inmates.** (a) The commissioner shall execute an interagency agreement with the commissioner of corrections to recover the state cost attributable to medical assistance eligibility for inmates of public institutions admitted to a medical institution on an inpatient basis. The annual amount to be transferred from the Department of Corrections under the agreement must include all eligible state medical

assistance costs, including administrative costs incurred by the Department of Human Services, attributable to inmates under state and county jurisdiction admitted to medical institutions on an inpatient basis that are related to the implementation of section 256B.055, subdivision 14, paragraph (c). This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2028, or upon federal approval, whichever is later, the commissioner shall execute an interagency agreement with the commissioner of corrections to recover the state cost attributable to medical assistance eligibility for inmates of public institutions admitted to a medical institution on an inpatient basis. The annual amount to be transferred from the Department of Corrections under the agreement must include all eligible state medical assistance costs, including administrative costs incurred by the Department of Human Services, attributable to inmates under state and county jurisdiction admitted to medical institutions on an inpatient basis that are related to the implementation of section 256B.0618, paragraph (b).

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

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; or

(3) by an eligible individual under 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, 2028.

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

Subdivision 1. **Generally.** Effective January 1, 2028, 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. A comprehensive care plan 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 justice-involved individual to (1) inform, inquire, and instruct providers on the individual's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, and (2) direct and coordinate clinical service components provided to the justice-involved individual. Service settings and components include but are not limited to education services, social services, probation, an individual's home, primary care, medication prescribers, disabilities services, and services from other mental health providers.

(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 to bridge prerelease and postrelease medical assistance services that support the physical, behavioral, and health-related social needs of justice-involved individuals.

(e) "Targeted case management services" means services that assist medical assistance eligible persons with accessing 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 consist of efforts beyond providing 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 postrelease follow-up through direct coordination between providers, including timely communication, active engagement of the individual when feasible, and facilitation of continuity of care upon 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 to 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.0623, is amended by adding a subdivision to read:

Subd. 15. **Billing limits.** Effective January 1, 2027, services under this section must not exceed four hours per week per recipient, with a maximum of 18 hours per month. Prior authorization is required for services exceeding 200 hours per year.

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

Subd. 78. **Carceral targeted case management.** Effective January 1, 2028, or upon federal approval, whichever is later, medical assistance covers carceral targeted case management services under section 256B.0619.

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

Sec. 17. Minnesota Statutes 2024, section 256B.0671, is amended by adding a subdivision to read:

Subd. 14. **Billing limits.** Child and family psychoeducation services under this section must not exceed two hours per day, three days per week per recipient.

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

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

Subd. 2. **Eligible individuals.** (a) 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. This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2028, or upon federal approval, whichever is later, notwithstanding section 256B.0618, 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.

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

Sec. 19. Minnesota Statutes 2024, section 256B.0761, subdivision 3, is amended to read:

Subd. 3. **Eligible correctional facilities.** (a) The commissioner's waiver application is limited to:

(1) three state correctional facilities to be determined by the commissioner of corrections, one of which must be the Minnesota Correctional Facility-Shakopee;

~~(2) two facilities for delinquent children and youth licensed under section 241.021, subdivision 2, identified in coordination with the Minnesota Juvenile Detention Association and the Minnesota Sheriffs' Association;~~

~~(3)~~ (2) four correctional facilities for adults licensed under section 241.021, subdivision 1, identified in coordination with the Minnesota Sheriffs' Association and the Association of Minnesota Counties; and

~~(4)~~ (3) one correctional facility owned and managed by a Tribal government or a facility located outside of the seven-county metropolitan area that has an inmate census with a significant proportion of Tribal members or American Indians.

(b) Additional facilities may be added to the waiver contingent on legislative authorization and appropriations.

Sec. 20. Minnesota Statutes 2024, section 256B.0943, is amended by adding a subdivision to read:

Subd. 15. **Billing limits.** (a) Skills training under this section must not exceed two hours per day, three days per week per recipient. Prior authorization is required for services exceeding 200 hours per year.

(b) Mental health behavioral aide services under this section must not exceed six hours per day, three days per week per recipient. Prior authorization is required for services exceeding 200 hours per year.

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

Sec. 21. Minnesota Statutes 2025 Supplement, section 256I.04, subdivision 2a, is amended to read:

Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph (b), an agency may not enter into an agreement with an establishment to provide housing support unless:

(1) the establishment is licensed by the Department of Health as a hotel and restaurant; a board and lodging establishment; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A. However, an establishment licensed by the Department of Health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the Department of Health;

(2) the residence is: (i) licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02, subdivision 4a, as a community residential setting by the commissioner of human services;

(3) the facility is licensed under chapter 144G and provides three meals a day; or

(4) effective ~~January 1, 2027~~ July 1, 2026, the establishment is licensed by the Department of Health as a board and lodging establishment and is certified by the commissioner as a recovery residence in accordance with section 254B.215, subdivision 3, that is subject to the requirements of section 256I.04, subdivisions 2a to 2f. The Department of Human Services must serve as the lead agency for agreements entered into under this clause.

(b) The requirements under paragraph (a) do not apply to establishments exempt from state licensure because they are:

(1) located on Indian reservations and subject to tribal health and safety requirements; or

(2) supportive housing establishments where an individual has an approved habitability inspection and an individual lease agreement.

(c) Supportive housing establishments that serve individuals who have experienced long-term homelessness and emergency shelters must participate in the homeless management information system and a coordinated assessment system as defined by the commissioner.

(d) Effective July 1, 2016, an agency shall not have an agreement with a provider of housing support unless all staff members who have direct contact with recipients:

(1) have skills and knowledge acquired through one or more of the following:

(i) a course of study in a health- or human services-related field leading to a bachelor of arts, bachelor of science, or associate's degree;

(ii) one year of experience with the target population served;

(iii) experience as a mental health certified peer specialist according to section 256B.0615; or

(iv) meeting the requirements for unlicensed personnel under sections 144A.43 to 144A.483;

(2) hold a current driver's license appropriate to the vehicle driven if transporting recipients;

(3) complete training on vulnerable adults mandated reporting and child maltreatment mandated reporting, where applicable; and

(4) complete housing support orientation training offered by the commissioner.

Sec. 22. 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. The balance of amounts appropriated under this paragraph that are unencumbered and unspent at the close of a fiscal year must be available in the next fiscal year for the same purposes and must not cancel to the fund from which the amounts were appropriated.

(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. 23. 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. 24. 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. 25. 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. 26. 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. 27. 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. 28. 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. 29. 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. 30. 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. 31. 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. 32. 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. 33. Laws 2025, First Special Session chapter 9, article 4, section 57, the effective date, is amended to read:

EFFECTIVE DATE. ~~Paragraph~~ Paragraphs (a) ~~is~~ and (b) are effective July 1, 2026, ~~paragraph (b) is effective July 1, 2027,~~ paragraph (c) is effective January 1, 2027, and paragraph (d) is effective July 1, 2026, or upon federal approval, whichever is later. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 34. Laws 2026, chapter 95, article 5, section 23, subdivision 7, is amended to read:

Subd. 7. **Billing limits.** ~~Eligible vendors of~~ Peer recovery support services must ~~limit an individual client to~~ not exceed 14 hours per week ~~for~~ per recipient, of which no more than two hours per day per recipient may be provided by telehealth. Peer recovery support services ~~from an individual provider of peer recovery support services~~ must not exceed 520 hours annually per recipient.

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

Sec. 35. **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 and must be available for 180 days postrelease.

EFFECTIVE DATE. This section is effective January 1, 2028, or upon federal approval, whichever is later.

Sec. 36. **REPEALER.**

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

EFFECTIVE DATE. This section is effective January 1, 2028, or upon federal approval, whichever is later.

ARTICLE 7
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, effective January 1, 2028, for programs licensed 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.

Sec. 3. **[245A.044] LICENSED NONRESIDENTIAL BEHAVIORAL HEALTH SERVICES.**

Subdivision 1. **License required for certain nonresidential behavioral health services.** (a) Beginning January 1, 2028, providers of nonresidential 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 must begin issuing licenses to providers listed in subdivision 1. The commissioner must transition providers certified under section 245I.011 and listed in subdivision 1 into licensure with a phased-in schedule determined by the commissioner. The commissioner must communicate the implementation schedule to providers 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 the licensure 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) If a provider fails to submit an application for licensure within six months of the application being made available, the commissioner must disenroll the provider from reimbursement for the following services:

(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 provider's licensing 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.

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 mental health clinic certification issued by the commissioner 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 are subject to 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 the required determination within 24 hours of first providing crisis stabilization services to an adult 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, or with an 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 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. 11. 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.~~

Sec. 12. 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.

Sec. 13. 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;

(3) children's therapeutic services and supports, as defined in section 256B.0943; or

(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 must 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. 14. 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. 15. 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. 16. 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, conducted according to section 245I.17.

Sec. 17. 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. 18. 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. Rehabilitative 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, rehabilitative mental health services include interventions to (1) restore a child or adolescent to an age-appropriate developmental trajectory that has 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.

Sec. 19. 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~~ 245I.24, subdivision 11. For a license holder under section 245I.17, a treatment plan is the integrated treatment plan developed according to section 245I.17, subdivision 13.

Sec. 20. 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. 21. Minnesota Statutes 2024, section 245I.03, is amended by adding a subdivision to read:

Subd. 11. **Quality assurance and improvement plan.** (a) 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. 22. 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. 23. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, as amended by Laws 2026, chapter 95, article 5, section 14, 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 that a mental health professional, clinical trainee, or behavioral health practitioner has previously taught to the child~~.

Sec. 24. 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~~.~~; and

(7) modeling service practices that respect the client, include the client in planning and implementation of the individual treatment plan, recognize the client's strengths, and coordinate with other involved parties and providers.

(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. 25. 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, approved by the staff person, 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. 26. Minnesota Statutes 2025 Supplement, section 245I.06, subdivision 3, is amended to read:

Subd. 3. **Treatment supervision and direct observation of mental health rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral aide or a mental health rehabilitation worker must receive direct observation from a mental health professional, clinical trainee, certified rehabilitation specialist, or behavioral health practitioner while the mental health behavioral aide or mental health rehabilitation worker provides treatment services to clients, no less than twice per month for the first six months of employment and once per month thereafter. The staff person performing the direct observation must approve of the progress note twice per month for the first six months of employment and as needed and identified in a supervision plan thereafter. Approval may be given through an attestation that is stored in the ~~employee~~ personnel file under section 245I.07.

(b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work must at a minimum consist of:

(1) monthly individual supervision; and

(2) direct observation twice per month.

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 for assessments under section 245I.17, subdivisions 11 and 12, and for treatment planning under section 245I.17, subdivision 13. Certified community behavioral health clinic service planning and authorization must comply with the standards in section 245I.17.

Sec. 29. Minnesota Statutes 2024, section 245I.10, subdivision 6, as amended by Laws 2026, chapter 95, article 5, section 15, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard

diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety, including withdrawal symptoms, medical conditions, and behavioral and emotional symptoms;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health and substance use disorder treatment, including but not limited to treatment for tobacco or nicotine use;

(10) cultural influences on the client; and

(11) substance use history, if applicable, including:

(i) amounts and types of substances, including but not limited to tobacco and nicotine products; frequency and duration; route of administration; periods of abstinence; and circumstances of relapse; and

(ii) the impact to functioning when under the influence of substances, including legal interventions.

(c) If the assessor cannot obtain the information that this paragraph requires without retraumatizing the client or harming the client's willingness to engage in treatment, the assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is 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. A license holder may select a different clinically appropriate screening tool if the tool is identified in a written policy and procedure under section 245I.03.

~~(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, including but not limited to tobacco use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client; and

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. ~~The assessor must make referrals for the client as to services required by law.~~

(g) Information from other providers and prior assessments may be used to complete the diagnostic assessment if the source of the information is documented in the diagnostic assessment.

(h) If the client screens positive for a need for substance use disorder treatment 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. The individual treatment plan must include direction for accessing crisis services when the license holder is aware of the client's need for crisis 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:

(1) outreach and engagement;

(2) documenting a plan of care for medical, behavioral health, and social services and supports in the integrated treatment plan;

(3) assisting with obtaining appointments;

(4) confirming appointments are kept;

(5) developing a crisis plan;

(6) tracking medication; and

(7) 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 triage 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 that is not under the direct supervision of a CCBHC engaged in a formal relationship with the CCBHC to deliver one or more of the required services or elements of required 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 triage and risk assessment" means a mandatory triage 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.

(c) A CCBHC must meet the requirements of this section and 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.

(d) The commissioner may deny a license to a CCBHC applicant or license holder on the basis of geographic area if a license holder does not meet federal criteria for identifying and addressing:

(1) a community's needs;

(2) gaps in access to mental health and substance use disorder services; and

(3) underserved populations to be served by the license holder as outlined in the community needs assessment.

(e) The commissioner shall communicate with licensed CCBHCs, applicants, and community partners before establishing and implementing changes in the licensure requirements.

(f) The commissioner shall update state licensing conditions for CCBHCs to align with changes to the federal CCBHC criteria. The commissioner may select a transition date on

which revisions to the federal CCBHC criteria become required as licensing conditions for CCBHCs.

(g) The commissioner shall publish the licensing standards consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration on a publicly available website.

Subd. 3. **Compliance with federal CCBHC standards.** (a) The commissioner must make the required federal attestation of compliance with state and federal standards to the Centers for Medicare and Medicaid Services (CMS) upon granting a license meeting all requirements of this section.

(b) The commissioner must renew the required attestation to CMS every 36 months if the license holder remains in good standing. If a CCBHC license is revoked during the 36-month term, the commissioner must publicly report the revocation.

(c) A license holder that has operated under an existing attestation to CMS for two years and three months must submit the documentation required under subdivision 2, paragraph (c), to the commissioner.

(d) The commissioner must complete a licensing review that includes an on-site inspection in the six months before the expiration of the federal attestation.

Subd. 4. **Required services and scope of licensure.** (a) 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 treatment 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.

(b) A CCBHC may offer the services listed in paragraph (a) directly or through its designated collaborating organization. The CCBHC must deliver the services in a manner reflecting person- and family-centered care.

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 as a designated collaborating organization.

(b) The CCBHC must submit a designated collaborating organization arrangement for approval to the commissioner as part of the licensing process.

(c) The commissioner must not approve a designated collaborating organization agreement under this section to provide services, other than mobile crisis services under section 245I.24, until the commissioner:

(1) implements a mechanism to administer payments for CCBHC services provided under a designated collaborating organization arrangement in a manner that ensures proper payment in compliance with state and federal law; or

(2) determines that the Medicaid Management Information System has the capability to pay for CCBHC services provided under a designated collaborating organization arrangement in compliance with state and federal law.

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 must 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 must 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. When developing the list, the commissioner must consider the adequacy of evidence to support the efficacy of the practice across cultures and ages, the workforce available, and the current availability of the practices in the state. At least 30 days before issuing the initial list or issuing any revisions, the commissioner must 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) Completion of 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 conduct 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 treatment.** (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 treatment services in chapter 245G, except as provided in this subdivision.

(b) Completion of a preliminary triage and risk assessment under this section fulfills the requirements to complete an initial services plan under section 245G.04, subdivision 1.

(c) Completion of a comprehensive evaluation under this section fulfills the requirements to administer a comprehensive assessment under section 245G.05.

(d) An integrated treatment plan under this section that contains a six-dimension analysis of the client's needs according to the most recently published edition of the American Society of Addiction Medicine 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. **Preliminary 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 a preliminary triage and risk assessment when a new client requests services or is referred to services. A license holder may conduct a preliminary triage and risk assessment in person, by telephone, or through other remote communication. Based on the acuity of needs as assessed in the preliminary 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) the 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 client's comprehensive evaluation no later than 60 calendar days after the date of the first request for services.

(b) A license holder must document all required services under subdivision 9 within the integrated treatment plan based on the client's needs.

(c) A license holder must review and update a client's integrated 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, updates to 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 integrated 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 section 245I.30, except that an initial or comprehensive assessment under this section fulfills the requirement to perform a standard diagnostic assessment. A license holder under this section may elect to provide services according to section 245I.31 under their license.

(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.

(c) A license holder under this section is exempt from licensure under sections 245I.22, 245I.24, 245I.30, and 245I.31.

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 for targeted case management.

Subd. 19. **Community needs assessment.** (a) The applicant or licensed clinic shall conduct a community needs assessment every 36 months that meets all requirements outlined in the federal criteria.

(b) An existing license holder must include an analysis of which needs from prior needs assessments have been improved by the operation of the CCBHC.

Subd. 20. **Staffing plan.** (a) Based on an approved community needs assessment, the applicant or license holder must complete a staffing plan that is responsive to the community needs assessment and meets the federal criteria no less often than every 36 months.

(b) The commissioner must provide feedback and technical assistance if the commissioner determines the license holder must revise the staffing plan.

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 federal and state CCBHC reporting standards 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.

Subd. 23. **Change of service area or population served.** (a) A CCBHC license holder may submit a request to the commissioner to modify the CCBHC's service area or population served by submitting updated documentation in a format approved by the commissioner.

(b) A CCBHC license holder may request a modification under this subdivision no more often than once every 12 months.

(c) The commissioner may deny a license holder's request to change its service area or populations under this subdivision if the license holder fails to demonstrate compliance with the federal criteria and scope of service requirements under section 223(a)(2)(D) of the federal Patient Access to Medicare Act of 2014.

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 with:

(1) interpersonal communication skills;

(2) community resource utilization and integration skills;

(3) crisis planning;

(4) relapse prevention skills;

(5) health care directives;

(6) budgeting and shopping skills;

(7) healthy lifestyle skills and practices;

(8) cooking and nutrition skills;

(9) transportation skills;

(10) mental illness symptom management skills;

(11) household management skills;

(12) employment-related skills; and

(13) parenting skills.

(d) "Community intervention" means a client's community assisting in the client's rehabilitation, including 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 services must be coordinated with, but must not duplicate, medication management services. Medication education services must be provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(f) "Transition to community living services" means services that maintain continuity of contact between the ARMHS 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 services;

(3) community intervention; and

(4) transition to community living services.

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) An ARMHS provider must complete a written functional assessment according to section 245I.10, subdivision 9, for each client.

(b) When an ARMHS provider 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. Minnesota Statutes 2024, section 245I.23, subdivision 4, is amended to read:

Subd. 4. **Required intensive residential treatment services.** (a) On a daily basis, the license holder must follow a client's treatment plan to provide intensive residential treatment services to the client to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to each client:

(1) daily rehabilitative mental health services;

(2) crisis prevention planning to assist a client with:

(i) identifying and addressing patterns in the client's history and experience of the client's mental illness; and

(ii) developing crisis prevention strategies that include de-escalation strategies that have been effective for the client in the past;

(3) health services and administering medication;

(4) co-occurring substance use disorder treatment;

(5) engaging the client's family and other natural supports in the client's treatment and educating the client's family and other natural supports to strengthen the client's social and family relationships; and

(6) making referrals for the client to other service providers in the community and supporting the client's transition from intensive residential treatment services to another setting.

(c) The license holder must include Illness Management and Recovery (IMR), Enhanced Illness Management and Recovery (E-IMR), or other similar interventions in the license holder's programming as approved by the commissioner.

Sec. 34. Minnesota Statutes 2024, section 245I.23, subdivision 5, is amended to read:

Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the license holder must follow a client's individual crisis treatment plan to provide services to the client in residential crisis stabilization to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to the client:

(1) daily crisis stabilization services as described in section 256B.0624, subdivision 7;

(2) rehabilitative mental health services;

(3) health services and administering the client's medications; and

(4) making referrals for the client to other service providers in the community and supporting the client's transition from residential crisis stabilization to another setting.

Sec. 35. Minnesota Statutes 2025 Supplement, section 245I.23, subdivision 7, is amended to read:

Subd. 7. **Intensive residential treatment services assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate and document the client's immediate needs, including the client's:

(1) health and safety, including the client's need for crisis assistance;

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of the client's admission, the license holder must complete an initial treatment plan for the client. The license holder must:

(1) base the client's initial treatment plan on the client's referral information and an assessment of the client's immediate needs;

(2) consider crisis assistance strategies that have been effective for the client in the past;

(3) identify the client's initial treatment goals, measurable treatment objectives, and specific interventions, and the frequency of interventions, that the license holder will use to help the client engage in treatment;

(4) identify the participants involved in the client's treatment planning. The client must be a participant; and

(5) ensure that a treatment supervisor approves of the client's initial treatment plan if a behavioral health practitioner or clinical trainee completes the client's treatment plan, notwithstanding section 245I.08, subdivision 3.

(c) According to section 245A.65, subdivision 2, paragraph (b), the license holder must complete an individual abuse prevention plan as part of a client's initial treatment plan.

(d) Within five days of the client's admission and again within 60 days after the client's admission, the license holder must complete a level of care assessment of the client. If the license holder determines that a client does not need a medically monitored level of service, a treatment supervisor must document how the client's admission to and continued services in intensive residential treatment services are medically necessary for the client.

(e) Within ten days of a client's admission, the license holder must complete or review and update the client's standard diagnostic assessment.

(f) Within ten days of a client's admission, the license holder must complete the client's individual treatment plan, notwithstanding section 245I.10, subdivision 8. Within 40 days after the client's admission and again within 70 days after the client's admission, the license holder must update the client's individual treatment plan. The license holder must focus the client's treatment planning on preparing the client for a successful transition from intensive residential treatment services to another setting. The individual treatment plan must be based on the client's diagnostic assessment and functional assessment and must contain, at a minimum, identified goals according to subdivision 4, paragraph (b), clauses (1) to (3), or subdivision 5, paragraph (b), clause (1), as applicable. In addition to the required elements of an individual treatment plan under section 245I.10, subdivision 8, the license holder must identify the following information in the client's individual treatment plan: (1) the client's referrals and resources for the client's health and safety; and (2) the staff persons who are responsible for following up with the client's referrals and resources. If the client does not receive a referral or resource that the client needs, the license holder must document the reason that the license holder did not make the referral or did not connect the client to a particular resource. The license holder is responsible for determining whether additional follow-up is required on behalf of the client.

(g) Within 30 days of the client's admission, the license holder must complete a functional assessment of the client. Within 60 days after the client's admission, the license holder must

update the client's functional assessment to include any changes in the client's functioning and symptoms.

(h) For a client with a current substance use disorder diagnosis and for a client whose substance use disorder screening in the client's standard diagnostic assessment indicates the possibility that the client has a substance use disorder, the license holder must complete a written assessment of the client's substance use within 30 days of the client's admission. In the substance use assessment, the license holder must: (1) evaluate the client's history of substance use, relapses, and hospitalizations related to substance use; (2) assess the effects of the client's substance use on the client's relationships including with family member and others; (3) identify financial problems, health issues, housing instability, and unemployment; (4) assess the client's legal problems, past and pending incarceration, violence, and victimization; and (5) evaluate the client's suicide attempts, noncompliance with taking prescribed medications, and noncompliance with psychosocial treatment.

(i) On a weekly basis, a mental health professional or certified rehabilitation specialist must review each client's treatment plan and individual abuse prevention plan. The license holder must document in the client's file each weekly review of the client's treatment plan and individual abuse prevention plan. An individual treatment plan must be updated based on new information gathered about the client's conditions, the client's level of participation, and whether identified interventions have had the intended effect.

Sec. 36. Minnesota Statutes 2025 Supplement, section 245I.23, subdivision 10, is amended to read:

Subd. 10. **Minimum treatment team staffing levels and ratios.** (a) The license holder must maintain a treatment team staffing level sufficient to:

(1) provide continuous daily coverage of all shifts;

(2) follow each client's treatment plan and meet each client's needs as identified in the client's treatment plan;

(3) implement program requirements; and

(4) safely monitor and guide the activities of each client, taking into account the client's level of behavioral and psychiatric stability, cultural needs, and vulnerabilities.

(b) The license holder must ensure that treatment team members:

(1) remain awake during all work hours; and

(2) are available to monitor and guide the activities of each client whenever clients are present in the program.

(c) On each shift, the license holder must maintain a treatment team staffing ratio of at least one treatment team member to nine clients. If the license holder is serving nine or fewer clients, at least one treatment team member on the day shift must be a mental health professional, clinical trainee, certified rehabilitation specialist, or behavioral health practitioner. If the license holder is serving more than nine clients, at least one of the treatment team members working during both the day and evening shifts must be a mental health professional, clinical trainee, certified rehabilitation specialist, or behavioral health practitioner.

(d) If the license holder provides residential crisis stabilization to clients and is serving at least one client in residential crisis stabilization and more than four clients in residential crisis stabilization and intensive residential treatment services, the license holder must maintain a treatment team staffing ratio on each shift of at least two treatment team members during the client's first 48 hours in residential crisis stabilization.

(e) The license holder must maintain documentation of a daily staffing schedule indicating the names and credentials of individuals providing services, according to the record retention requirements under section 245A.041.

Sec. 37. Minnesota Statutes 2024, section 245I.23, subdivision 12, is amended to read:

Subd. 12. **Daily documentation.** (a) For each day that a client is present in the program, the license holder must provide a daily summary in the client's file that includes observations about the client's behavior and symptoms, including any critical incidents in which the client was involved, and documentation of a daily medically necessary rehabilitation service according to section 245I.08.

(b) For each day that a client is not present in the program, the license holder must document the reason for a client's absence in the client's file.

Sec. 38. Minnesota Statutes 2024, section 245I.23, subdivision 17, is amended to read:

Subd. 17. **Admissions referrals and determinations.** (a) The license holder must identify the information that the license holder needs to make a determination about a person's admission referral.

(b) The license holder must:

(1) always be available to receive referral information about a person seeking admission to the license holder's program;

(2) respond to the referral source within eight hours of receiving a referral and, within eight hours, communicate with the referral source about what information the license holder needs to make a determination concerning the person's admission;

(3) consider the license holder's staffing ratio and the areas of treatment team members' competency when determining whether the license holder is able to meet the needs of a person seeking admission; ~~and~~

(4) determine whether to admit a person within 72 hours of receiving all necessary information from the referral source~~.~~; and

(5) document client eligibility according to subdivision 15, paragraph (a), and subdivision 16.

Sec. 39. **[245I.24] MOBILE CRISIS RESPONSE SERVICES.**

Subdivision 1. **Generally.** (a) Mobile crisis response services provide short-term, face-to-face mental health care in community settings for adults and children experiencing crisis to help individuals 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 an 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 services" means individualized mental health services that are designed to restore an 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 crisis stabilization services that are 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, crisis assessments, and crisis 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 at least every six months, in a form and manner prescribed by the commissioner.

(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 an individual's changing intervention and care needs, 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 are provided.

(d) The license holder must coordinate services with:

(1) county emergency services under section 245.469, community hospitals, ambulance services, 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 needed; 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 reducing access to means of suicide, 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:

(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) 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.

(e) 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, the individual's family, and other natural supports to assess whether a crisis exists.

(d) A crisis assessment must include a determination of:

(1) whether the individual is willing to voluntarily engage in treatment;

(2) whether the individual has an advance directive; and

(3) gathering the individual's information and history from involved family or other natural supports.

(e) If a team determines that the individual does not need an acute level of care, the team must provide services or service coordination if the individual has a co-occurring substance use disorder and is otherwise eligible for services.

(f) If, after completing a crisis assessment, 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 staff responsible for triage or 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. 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 able 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 a licensing application submitted 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. 40. **[245I.30] CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

Subdivision 1. **Generally.** (a) "Children's therapeutic services and supports" means a flexible package of community-based mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness. Interventions 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 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 must consist of 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. 41. **[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) A children's day treatment program must be licensed for a specific location of operation and must not be 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. 42. 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.

Sec. 43. 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.

Sec. 44. 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.

~~(c) 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.~~

Sec. 45. 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.

Sec. 46. Minnesota Statutes 2024, section 256B.0624, subdivision 4, as amended by Laws 2026, chapter 88, article 1, section 123, 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 9530.6510 to 9530.6590, 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.

Sec. 47. 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 setting 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.

(b) 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.

(c) A provider under this subdivision must follow the requirements under section 245I.24, subdivisions 4, paragraphs (c) and (d), and 9.

Sec. 48. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 5m, as amended by Laws 2026, chapter 95, article 5, section 27, 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 must reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner must include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner must ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate must be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section ~~245.735, subdivision 3, paragraph (a), clauses (6) and (7)~~ 245I.17, subdivision 4; and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment must be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section ~~245.735, subdivision 3, paragraph (a), clause (6)~~ 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 must 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 must rebase CCBHC rates once every two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services;

(5) the commissioner must provide for a 60-day appeals process after notice of the results of the rebasing;

(6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal Medicaid rate is not eligible for the CCBHC rate methodology;

(7) payments for CCBHC services to individuals enrolled in managed care must be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner must complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the CCBHC daily bundled rate for each CCBHC must be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update must occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope must occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

(d) Managed care plans and county-based purchasing plans must reimburse CCBHC providers at the CCBHC daily bundled rate. The commissioner must monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between

managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner must implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC must receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be ~~certified~~ licensed and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC must receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner must notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section must be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims must be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December

31 of a calendar year, claims must be submitted to and paid by the commissioner beginning on July 1 of the following year.

(g) Peer services provided by a CCBHC ~~certified~~ 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).

Sec. 49. 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, provided 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.

Sec. 50. 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. 51. 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 on administrative tasks 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. 52. 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. 53. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, as amended by Laws 2026, chapter 95, article 7, section 25, 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 services agency adult protective services or the agency's designee or a federally recognized Indian Tribe that entered into a contractual agreement with the

commissioner of human services to operate adult protective services is the lead investigative agency for all other reports, including but not limited to reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659 or 256B.85.

Sec. 54. **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. 55. **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.

Sec. 56. **EFFECTIVE DATE.**

This article is effective January 1, 2028.

ARTICLE 8
UNIFORM SERVICE STANDARDS CONFORMING CHANGES

Section 1. Minnesota Statutes 2024, section 13.46, subdivision 7, is amended to read:

Subd. 7. **Mental health data.** (a) Mental health data are private data on individuals and shall not be disclosed, except:

(1) pursuant to section 13.05, as determined by the responsible authority for the community mental health center, mental health division, or provider;

(2) pursuant to court order;

(3) pursuant to a statute specifically authorizing access to or disclosure of mental health data or as otherwise provided by this subdivision;

(4) to personnel of the welfare system working in the same program or providing services to the same individual or family to the extent necessary to coordinate services, provided that a health record may be disclosed only as provided under section 144.293;

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

(6) with the consent of the client or patient.

(b) An agency of the welfare system may not require an individual to consent to the release of mental health data as a condition for receiving services or for reimbursing a community mental health center, mental health division of a county, or provider under contract to deliver mental health services.

(c) Notwithstanding any other law to the contrary, a community mental health center, mental health division of a county, or a mental health provider must disclose mental health data to a law enforcement agency if the law enforcement agency provides the name of a client or patient and communicates that the:

(1) client or patient is currently involved in a mental health crisis as defined in section ~~256B.0624, subdivision 2, paragraph (j)~~ 245I.24, subdivision 2, paragraph (g), to which the law enforcement agency has responded; and

(2) data is necessary to protect the health or safety of the client or patient or of another person.

The scope of disclosure under this paragraph is limited to the minimum necessary for law enforcement to safely respond to the mental health crisis. Disclosure under this paragraph may include the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the client or patient, if known; and strategies to address the mental health crisis. A law enforcement agency that obtains mental health data under this paragraph shall maintain a record of the requestor, the provider of the data, and the client or patient name. Mental health data obtained by a law enforcement agency under this paragraph are private data on individuals and must not be used by the law enforcement agency for any other purpose. A law enforcement agency that obtains mental health data under this paragraph shall inform the subject of the data that mental health data was obtained.

(d) In the event of a request under paragraph (a), clause (6), a community mental health center, county mental health division, or provider must release mental health data to Criminal

Mental Health Court personnel in advance of receiving a copy of a consent if the Criminal Mental Health Court personnel communicate that the:

(1) client or patient is a defendant in a criminal case pending in the district court;

(2) data being requested is limited to information that is necessary to assess whether the defendant is eligible for participation in the Criminal Mental Health Court; and

(3) client or patient has consented to the release of the mental health data and a copy of the consent will be provided to the community mental health center, county mental health division, or provider within 72 hours of the release of the data.

For purposes of this paragraph, "Criminal Mental Health Court" refers to a specialty criminal calendar of the Hennepin County District Court for defendants with mental illness and brain injury where a primary goal of the calendar is to assess the treatment needs of the defendants and to incorporate those treatment needs into voluntary case disposition plans. The data released pursuant to this paragraph may be used for the sole purpose of determining whether the person is eligible for participation in mental health court. This paragraph does not in any way limit or otherwise extend the rights of the court to obtain the release of mental health data pursuant to court order or any other means allowed by law.

Sec. 2. Minnesota Statutes 2024, section 144.294, subdivision 2, is amended to read:

Subd. 2. **Disclosure to law enforcement agency.** Notwithstanding section 144.293, subdivisions 2 and 4, a provider must disclose health records relating to a patient's mental health to a law enforcement agency if the law enforcement agency provides the name of the patient and communicates that the:

(1) patient is currently involved in a mental health crisis as defined in section ~~256B.0624, subdivision 2, paragraph (j)~~ 245I.24, subdivision 2, paragraph (g), to which the law enforcement agency has responded; and

(2) disclosure of the records is necessary to protect the health or safety of the patient or of another person.

The scope of disclosure under this subdivision is limited to the minimum necessary for law enforcement to safely respond to the mental health crisis. The disclosure may include the name and telephone number of the psychiatrist, psychologist, therapist, mental health professional, practitioner, or case manager of the patient, if known; and strategies to address the mental health crisis. A law enforcement agency that obtains health records under this subdivision shall maintain a record of the requestor, the provider of the information, and the patient's name. Health records obtained by a law enforcement agency under this

subdivision are private data on individuals as defined in section 13.02, subdivision 12, and must not be used by law enforcement for any other purpose. A law enforcement agency that obtains health records under this subdivision shall inform the patient that health records were obtained.

Sec. 3. Minnesota Statutes 2025 Supplement, section 245.4835, subdivision 2, is amended to read:

Subd. 2. **Failure to maintain expenditures.** (a) If a county does not comply with subdivision 1, the commissioner shall require the county to develop a corrective action plan according to a format and timeline established by the commissioner. If the commissioner determines that a county has not developed an acceptable corrective action plan within the required timeline, or that the county is not in compliance with an approved corrective action plan, the protections provided to that county under section 245.485 do not apply.

(b) The commissioner shall consider the following factors to determine whether to approve a county's corrective action plan:

(1) the degree to which a county is maximizing revenues for mental health services from noncounty sources;

(2) the degree to which a county is expanding use of alternative services that meet mental health needs, but do not count as mental health services within existing reporting systems. If approved by the commissioner, the alternative services must be included in the county's base as well as subsequent years. The commissioner's approval for alternative services must be based on the following criteria:

(i) the service must be provided to children or adults with mental illness;

(ii) the services must be based on an individual treatment plan or individual community support plan as defined in the Comprehensive Mental Health Act; and

(iii) the services must be supervised by a mental health professional and provided by staff who meet the staff qualifications defined in sections ~~256B.0943, subdivision 7~~ 245I.30, subdivision 4, and ~~256B.0623, subdivision 5~~ 245I.22, subdivision 5.

(c) Additional county expenditures to make up for the prior year's underspending may be spread out over a two-year period.

Sec. 4. Minnesota Statutes 2025 Supplement, section 245.4871, subdivision 4, is amended to read:

Subd. 4. **Case management service provider.** (a) "Case management service provider" means a case manager or case manager associate employed by the county or other entity authorized by the county board to provide case management services specified in subdivision 3 for the child with serious mental illness and the child's family.

(b) A case manager must:

(1) have experience and training in working with children;

(2) be a mental health practitioner under section 245I.04, subdivision 4, or have at least a bachelor's degree in one of the behavioral sciences or a related field including, but not limited to, social work, psychology, or nursing from an accredited college or university or meet the requirements of paragraph (d);

(3) have experience and training in identifying and assessing a wide range of children's needs;

(4) be knowledgeable about local community resources and how to use those resources for the benefit of children and their families; and

(5) meet the supervision and continuing education requirements of paragraphs (e), (f), and (g), as applicable.

(c) A case manager may be a member of any professional discipline that is part of the local system of care for children established by the county board.

(d) A case manager who is not a mental health practitioner and does not have a bachelor's degree or who has a bachelor's degree that is not in one of the behavioral sciences or related fields must meet one of the requirements in clauses (1) to (5):

(1) have three or four years of experience as a case manager associate;

(2) be a registered nurse without a bachelor's degree who has a combination of specialized training in psychiatry and work experience consisting of community interaction and involvement or community discharge planning in a mental health setting totaling three years;

(3) be a person who qualified as a case manager under the 1998 Department of Human Services waiver provision and meets the continuing education, supervision, and mentoring requirements in this section;

(4) prior to direct service delivery, complete at least 80 hours of specific training on the characteristics and needs of children with serious mental illness that is consistent with national practices standards; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of children with serious mental illness, consistent with national practices standards.

(e) A case manager with at least 2,000 hours of supervised experience in the delivery of mental health services to children must receive regular ongoing supervision and clinical supervision totaling 38 hours per year, of which at least one hour per month must be clinical supervision regarding individual service delivery with a case management supervisor. The other 26 hours of supervision may be provided by a case manager with two years of experience. Group supervision may not constitute more than one-half of the required supervision hours.

(f) A case manager without 2,000 hours of supervised experience in the delivery of mental health services to children with mental illness must:

(1) begin 40 hours of training approved by the commissioner of human services in case management skills and in the characteristics and needs of children with serious mental illness before beginning to provide case management services; and

(2) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour each week until the requirement of 2,000 hours of experience is met.

(g) A case manager who is not licensed, registered, or certified by a health-related licensing board must receive 30 hours of continuing education and training in serious mental illness and mental health services every two years.

(h) Clinical supervision must be documented in the child's record. When the case manager is not a mental health professional, the county board must provide or contract for needed clinical supervision.

(i) The county board must ensure that the case manager has the freedom to access and coordinate the services within the local system of care that are needed by the child.

(j) A case manager associate (CMA) must:

(1) work under the direction of a case manager or case management supervisor;

(2) be at least 21 years of age;

(3) have at least a high school diploma or its equivalent; and

(4) meet one of the following criteria:

(i) have an associate of arts degree in one of the behavioral sciences or human services;

(ii) be a registered nurse without a bachelor's degree;

(iii) have three years of life experience as a primary caregiver to a child with serious mental illness as defined in subdivision 6 within the previous ten years;

(iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

(v) have 6,000 hours of supervised work experience in the delivery of mental health services to children with mental illness; hours worked as a mental health behavioral aide I or II under section ~~256B.0943, subdivision 7~~ 245I.30, subdivision 4,, may count toward the 6,000 hours of supervised work experience.

Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (v) may qualify as a case manager after three years of supervised experience as a case manager associate.

(k) Case manager associates must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (f), clause (1);

(2) receive at least 40 hours of continuing education in serious mental illness and mental health service annually; and

(3) receive at least five hours of mentoring per week from a case management mentor. A "case management mentor" means a qualified, practicing case manager or case management supervisor who teaches or advises and provides intensive training and clinical supervision to one or more case manager associates. Mentoring may occur while providing direct services to consumers in the office or in the field and may be provided to individuals or groups of case manager associates. At least two mentoring hours per week must be individual and face-to-face.

(l) A case management supervisor must meet the criteria for a mental health professional as specified in subdivision 27.

(m) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to child immigrants with serious mental illness of the same ethnic group as the immigrant if the person:

(1) is currently enrolled in and is actively pursuing credits toward the completion of a bachelor's degree in one of the behavioral sciences or related fields at an accredited college or university;

(2) completes 40 hours of training as specified in this subdivision; and

(3) receives clinical supervision at least once a week until the requirements of obtaining a bachelor's degree and 2,000 hours of supervised experience are met.

Sec. 5. Minnesota Statutes 2024, section 245.4882, subdivision 6, is amended to read:

Subd. 6. **Crisis admissions and stabilization.** (a) A child may be referred for residential treatment services under this section for the purpose of crisis stabilization by:

(1) a mental health professional as defined in section 245I.04, subdivision 2;

(2) a physician licensed under chapter 147 who is assessing a child in an emergency department; or

(3) a member of a mobile crisis team who meets the qualifications under section ~~256B.0624, subdivision 5~~ 245I.24, subdivision 5.

(b) A provider making a referral under paragraph (a) must conduct an assessment of the child's mental health needs and make a determination that the child is experiencing a mental health crisis and is in need of residential treatment services under this section.

(c) A child may receive services under this subdivision for up to 30 days and must be subject to the screening and admissions criteria and processes under section 245.4885 thereafter.

Sec. 6. Minnesota Statutes 2025 Supplement, section 245.735, subdivision 4d, is amended to read:

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); and

(3) section 245I.10, subdivisions 7 and 8~~; and~~.

~~(4) section 256B.0943, subdivision 6, paragraph (b), clause (2).~~

Sec. 7. Minnesota Statutes 2024, section 245A.26, subdivision 3, is amended to read:

Subd. 3. **Eligibility for services.** An individual is eligible for children's residential crisis stabilization services if the individual is under 21 years of age and meets the eligibility criteria for crisis services under section ~~256B.0624, subdivision 3~~ 245I.24, subdivision 3.

Sec. 8. Minnesota Statutes 2024, section 245A.26, subdivision 4, is amended to read:

Subd. 4. **Required services; providers.** (a) A license holder providing residential crisis stabilization services must continually follow a client's individual crisis treatment plan to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to a client:

(1) crisis stabilization services as described in section ~~256B.0624, subdivision 7~~ 245I.24, subdivision 9;

(2) mental health services as specified in the client's individual crisis treatment plan, according to the client's treatment needs;

(3) health services and medication administration, if applicable; and

(4) referrals for the client to community-based treatment providers and support services for the client's transition from residential crisis stabilization to another treatment setting.

(c) Children's residential crisis stabilization services must be provided by a qualified staff person listed in section ~~256B.0624, subdivision 8~~ 245I.24, subdivision 9, paragraph (b), according to the scope of practice for the individual staff person's position.

Sec. 9. Minnesota Statutes 2024, section 245A.26, subdivision 5, is amended to read:

Subd. 5. **Assessment and treatment planning.** (a) Within 12 hours of a client's admission for residential crisis stabilization, the license holder must assess the client and document the client's immediate needs, including the client's:

(1) health and safety, including the need for crisis assistance;

(2) need for connection to family and other natural supports;

(3) if applicable, housing and legal issues; and

(4) if applicable, responsibilities for children, family, and other natural supports, and employers.

(b) Within 24 hours of a client's admission for residential crisis stabilization, the license holder must complete a crisis treatment plan for the client, according to the requirements for a crisis treatment plan under section ~~256B.0624, subdivision 11~~ 245I.24, subdivision 11. The license holder must base the client's crisis treatment plan on the client's referral information and the assessment of the client's immediate needs under paragraph (a). A mental health professional or a clinical trainee under the supervision of a mental health professional must complete the crisis treatment plan. A crisis treatment plan completed by a clinical trainee must contain documentation of approval, as defined in section 245I.02, subdivision 2, by a mental health professional within five business days of initial completion by the clinical trainee.

(c) A mental health professional must review a client's crisis treatment plan each week and document the weekly reviews in the client's client file.

(d) For a client receiving children's residential crisis stabilization services who is 18 years of age or older, the license holder must complete an individual abuse prevention plan for the client, pursuant to section 245A.65, subdivision 2, as part of the client's crisis treatment plan.

Sec. 10. 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~~ 245I.30, 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. 11. Minnesota Statutes 2024, section 245I.23, subdivision 5, is amended to read:

Subd. 5. **Required residential crisis stabilization services.** (a) On a daily basis, the license holder must follow a client's individual crisis treatment plan to provide services to the client in residential crisis stabilization to improve the client's functioning.

(b) The license holder must offer and have the capacity to directly provide the following treatment services to the client:

(1) crisis stabilization services as described in section ~~256B.0624, subdivision 7~~ 245I.24, subdivision 9;

(2) rehabilitative mental health services;

(3) health services and administering the client's medications; and

(4) making referrals for the client to other service providers in the community and supporting the client's transition from residential crisis stabilization to another setting.

Sec. 12. Minnesota Statutes 2024, section 245I.23, subdivision 8, is amended to read:

Subd. 8. **Residential crisis stabilization assessment and treatment planning.** (a) Within 12 hours of a client's admission, the license holder must evaluate the client and document the client's immediate needs, including the client's:

(1) health and safety, including the client's need for crisis assistance;

(2) responsibilities for children, family and other natural supports, and employers; and

(3) housing and legal issues.

(b) Within 24 hours of a client's admission, the license holder must complete a crisis treatment plan for the client under section ~~256B.0624, subdivision 11~~ 245I.24, subdivision 11. The license holder must base the client's crisis treatment plan on the client's referral information and an assessment of the client's immediate needs.

(c) Section 245A.65, subdivision 2, paragraph (b), requires the license holder to complete an individual abuse prevention plan for a client as part of the client's crisis treatment plan.

Sec. 13. Minnesota Statutes 2024, section 245I.23, subdivision 16, is amended to read:

Subd. 16. **Residential crisis stabilization services admission criteria.** An eligible client for residential crisis stabilization is an individual who is age 18 or older and meets the eligibility criteria in section ~~256B.0624, subdivision 3~~ 245I.24, subdivision 3.

Sec. 14. Minnesota Statutes 2024, section 256B.092, subdivision 14, is amended to read:

Subd. 14. **Reduce avoidable behavioral crisis emergency room admissions, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have had two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section 245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

(1) conduct a functional assessment of the crisis incident as defined in section 245D.02, subdivision 11, which led to the hospitalization with the goal of developing proactive strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable hospitalizations due to a behavioral crisis;

(2) use the results of the functional assessment to amend the support plan set forth in section 245D.02, subdivision 4b, to address the potential need for additional staff training, increased staffing, access to crisis mobility services, mental health services, use of technology, and crisis stabilization services in section ~~256B.0624, subdivision 7~~ 245I.24, subdivision 9; and

(3) identify the need for additional consultation, testing, and mental health crisis intervention team services as defined in section 245D.02, subdivision 20, psychotropic medication use and monitoring under section 245D.051, and the frequency and duration of ongoing consultation.

(b) For the purposes of this subdivision, "institution" includes, but is not limited to, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

Sec. 15. Minnesota Statutes 2024, section 256B.49, subdivision 25, is amended to read:

Subd. 25. **Reduce avoidable behavioral crisis emergency room admissions, psychiatric inpatient hospitalizations, and commitments to institutions.** (a) Persons receiving home and community-based services authorized under this section who have two or more admissions within a calendar year to an emergency room, psychiatric unit, or institution must receive consultation from a mental health professional as defined in section 245.462, subdivision 18, or a behavioral professional as defined in the home and community-based services state plan within 30 days of discharge. The mental health professional or behavioral professional must:

(1) conduct a functional assessment of the crisis incident as defined in section 245D.02, subdivision 11, which led to the hospitalization with the goal of developing proactive strategies as well as necessary reactive strategies to reduce the likelihood of future avoidable hospitalizations due to a behavioral crisis;

(2) use the results of the functional assessment to amend the support plan in section 245D.02, subdivision 4b, to address the potential need for additional staff training, increased staffing, access to crisis mobility services, mental health services, use of technology, and crisis stabilization services in section ~~256B.0624, subdivision 7~~ 245I.24, subdivision 9; and

(3) identify the need for additional consultation, testing, mental health crisis intervention team services as defined in section 245D.02, subdivision 20, psychotropic medication use and monitoring under section 245D.051, and the frequency and duration of ongoing consultation.

(b) For the purposes of this subdivision, "institution" includes, but is not limited to, the Anoka-Metro Regional Treatment Center and the Minnesota Security Hospital.

Sec. 16. Minnesota Statutes 2025 Supplement, section 256L.03, subdivision 5, as amended by Laws 2026, chapter 95, article 5, section 38, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

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

(e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

(f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

(g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention, crisis stabilization provided in a community setting, or crisis assessment as defined in section ~~256B.0624, subdivision 2~~ 245I.24, subdivision 2.

Sec. 17. **EFFECTIVE DATE.**

This article is effective January 1, 2028.

ARTICLE 9
AGING AND DISABILITY SERVICES

Section 1. Minnesota Statutes 2025 Supplement, section 144.0724, subdivision 11, is amended to read:

Subd. 11. **Nursing facility level of care.** (a) For purposes of medical assistance payment of long-term care services, a recipient must be determined, using assessments defined in subdivision 4, to meet one of the following nursing facility level of care criteria:

(1) the person requires formal clinical monitoring at least once per day;

(2) the person needs the assistance of another person or constant supervision to begin and complete at least four of the following activities of living: bathing, bed mobility, dressing, eating, grooming, toileting, transferring, and walking;

(3) the person needs the assistance of another person or constant supervision to begin and complete toileting, transferring, or positioning and the assistance cannot be scheduled;

(4) the person has significant difficulty with memory, using information, daily decision making, or behavioral needs that require intervention;

(5) the person has had a qualifying nursing facility stay of at least 90 days;

(6) the person meets the nursing facility level of care criteria determined 90 days after admission or on the first quarterly assessment after admission, whichever is later; or

(7) the person is determined to be at risk for nursing facility admission or readmission ~~through a face-to-face long-term care consultation assessment as specified in section 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, by a county, Tribe, or managed care organization under contract with the Department of Human Services~~. The person is considered at risk under this clause if the person currently lives alone or will live alone or be homeless without the person's current housing and also meets one of the following criteria:

(i) the person has experienced a fall resulting in a fracture;

(ii) the person has been determined to be at risk of maltreatment or neglect, including self-neglect; or

(iii) the person has a sensory impairment that substantially impacts functional ability and maintenance of a community residence.

(b) The assessment used to establish medical assistance payment for nursing facility services must be the most recent assessment performed under subdivision 4, paragraph (b), that occurred no more than 90 calendar days before the effective date of medical assistance eligibility for payment of long-term care services. In no case shall medical assistance payment for long-term care services occur prior to the date of the determination of nursing facility level of care.

(c) The assessment used to establish medical assistance payment for long-term care services provided under chapter 256S and section 256B.49 and alternative care payment for services provided under section 256B.0913 must be the most recent face-to-face assessment performed under section 256B.0911, subdivision 17 to 21, 23, 24, 27, or 28, that occurred no more than one calendar year before the effective date of medical assistance eligibility for payment of long-term care services.

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

Sec. 2. Minnesota Statutes 2024, section 245A.04, subdivision 2, is amended to read:

Subd. 2. **Notification of affected municipality.** The commissioner must not issue a license under this chapter without giving 30 calendar days' written notice to the affected

municipality or other political subdivision unless the program is considered a permitted single-family residential use under sections 245A.11 and 245A.14. If the program is considered a permitted single-family residence, the commissioner must give the affected municipality or other political subdivision written notice of the issuance no later than five days after issuing the license, excluding weekends and holidays. The written notice must include the prospective license holder's name and contact information, the license type and capacity, and the proposed address of the licensed facility or program. The commissioner may provide notice through electronic communication. The notification must be given before the first issuance of a license under this chapter and annually after that time if annual notification is requested in writing by the affected municipality or other political subdivision. State funds must not be made available to or be spent by an agency or department of state, county, or municipal government for payment to a residential or nonresidential program licensed under this chapter until the provisions of this subdivision have been complied with in full. The provisions of this subdivision shall not apply to programs located in hospitals.

EFFECTIVE DATE. This section is effective July 1, 2026, and applies to licenses issued on or after that date.

Sec. 3. Minnesota Statutes 2024, section 245A.04, subdivision 2a, is amended to read:

Subd. 2a. **Meeting fire and safety codes.** (a) An applicant or license holder under sections 245A.01 to 245A.16 must document compliance with applicable building codes, fire and safety codes, health rules, and zoning ordinances, or document that an appropriate waiver has been granted.

(b) At the request of a county or local unit of government, the commissioner may delegate to a county agency or local unit of government the commissioner's or local agency's authority to inspect an existing residential program serving six or fewer persons for compliance with zoning ordinances and applicable physical plant licensing requirements. If the commissioner delegates the commissioner's or local agency's authority to a county agency or local unit of government under this subdivision, the commissioner must execute a formal delegation of authority that clearly specifies what authority is being delegated to the county agency or local unit of government, that the commissioner is responsible for any costs incurred by the county agency or local unit of government for conducting inspections under delegated authority, and that the county agency or local unit of government must not assess any additional fees for conducting an inspection under delegated authority. When conducting an inspection under delegated authority, the county agency or local unit of government must provide the subject of the inspection with a copy of the delegation of authority.

(c) When a county agency or local unit of government is conducting an inspection under delegated authority as provided in paragraph (b), the county agency or local unit of government and the agency responsible for licensing inspections must coordinate inspections to minimize visits to and disruptions of the residential program. A county agency or local unit of government conducting an inspection must notify the commissioner of any violations or concerns within ten days of the inspection, excluding weekends and holidays. A county agency or local unit of government that conducts inspections under this subdivision must not inspect a residential program more frequently than annually, except a follow-up inspection is permitted before the next annual inspection to verify correction of a violation discovered during the most recent inspection.

(d) The commissioner must ensure that laws, rules, and codes are uniformly enforced throughout the state by reviewing at least every four years each county agency and local unit of government conducting inspections under this subdivision for compliance with this subdivision and other applicable laws and rules.

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

Sec. 4. Minnesota Statutes 2024, section 245A.042, is amended by adding a subdivision to read:

Subd. 7. **Colocation of certain home and community-based residential settings.** (a) Effective July 1, 2026, the commissioner must not authorize services in or issue an initial license under this chapter or chapter 245D for any of the following residential settings or programs unless the proposed setting meets the heightened home and community-based setting standards described in this subdivision:

(1) a community residential setting, as defined in section 245D.02, subdivision 4a;

(2) an adult foster care home;

(3) a setting providing customized living services with a resident capacity of six or fewer;

(4) a setting providing 24-hour customized living services with a resident capacity of six or fewer; and

(5) an assisted living facility licensed under chapter 144G with a resident capacity of six or fewer.

(b) Newly licensed settings enumerated in paragraph (a) must not be located on the same property or on an adjoining property of any existing community residential setting, any existing adult foster care setting, any existing setting providing family residential services

to an adult, any existing setting providing customized living services with a resident capacity of six or fewer, any existing setting providing 24-hour customized living services with a resident capacity of six or fewer, or any existing assisted living facility licensed under chapter 144G with a resident capacity of six or fewer. The requirements of this paragraph apply regardless of who owns or controls the existing setting. The commissioner must comply with section 245A.11, subdivision 4, when authorizing services or issuing an initial license under this subdivision.

(c) For the purposes of this subdivision, "adjoining property" means a property that shares a common boundary line with another property. Adjoining property also includes properties that meet at a common corner point. The presence of a right-of-way or public easement, including but not limited to a bicycle path, alley, or residential street, between adjoining properties, including between properties that but for the right-of-way or public easement would share a common corner point, are adjoining properties.

Sec. 5. Minnesota Statutes 2024, section 245D.12, is amended to read:

245D.12 INTEGRATED COMMUNITY SUPPORTS~~; SETTING CAPACITY REPORT~~.

Subdivision 1. **Setting capacity report.** (a) The license holder providing integrated community support, as defined in section 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to the commissioner to ensure the identified location of service delivery meets the criteria of the home and community-based service requirements as specified in section 256B.492.

(b) The license holder shall provide the setting capacity report on the forms and in the manner prescribed by the commissioner. The report must include:

(1) the address of the multifamily housing building where the license holder delivers integrated community supports and owns, leases, or has a direct or indirect financial relationship with the property owner;

(2) the total number of living units in the multifamily housing building described in clause (1) where integrated community supports are delivered;

(3) the total number of living units in the multifamily housing building described in clause (1), including the living units identified in clause (2);

(4) the total number of people who could reside in the living units in the multifamily housing building described in clause (2) and receive integrated community supports; and

(5) the percentage of living units that are controlled by the license holder in the multifamily housing building by dividing clause (2) by clause (3).

(c) Only one license holder may deliver integrated community supports at the address of the multifamily housing building.

Subd. 2. **Licensure moratorium.** (a) Except as permitted in this subdivision, the commissioner must not issue an initial license under this chapter authorizing integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause (8), and must not approve a license change adding integrated community supports to an existing license under this chapter.

(b) The commissioner may approve an exception to the moratorium only when the applicant or licensee meets all requirements under subdivision 1, the request is not superseded by temporary moratoriums under section 245A.03, subdivision 7a, and the applicant submits documentation demonstrating compliance with:

(1) federal and state home and community-based services requirements for provider-controlled settings;

(2) the prohibition on the use of Medicaid money for room and board under United States Code, title 42, section 1396n(c); and

(3) all licensing requirements applicable to integrated community supports under this chapter.

(c) In determining whether to approve an exception, the commissioner must consider statewide and regional capacity for integrated community supports based on needs determination processes under section 245A.03, subdivision 7, paragraph (e).

(d) A determination under this subdivision is final and not subject to appeal.

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

Sec. 6. Minnesota Statutes 2024, section 256.01, subdivision 21, is amended to read:

Subd. 21. **Interagency ~~agreement~~ agreements with Department of Health.** (a) The commissioner of human services shall amend the interagency agreement with the commissioner of health to certify nursing facilities for participation in the medical assistance program, to require the commissioner of health, as a condition of the agreement, to comply beginning July 1, 2005, with action plans included in the annual survey and certification quality improvement report required under section 144A.10, subdivision 17.

(b) The commissioners of health and human services must execute an interagency agreement to determine on behalf of the commissioner of health whether an assisted living facility for which either an applicant is seeking a provisional license under chapter 144G or a licensee is seeking to relocate under section 144G.195 meets the standards described in section 245A.042, subdivision 7.

Sec. 7. Minnesota Statutes 2025 Supplement, section 256.4792, subdivision 1, is amended to read:

Subdivision 1. **Long-term services and supports loan program.** The commissioner of human services shall establish a loan program to provide operating loans to eligible long-term services and supports providers. ~~The commissioner shall initiate the application process for the loan described in this section on an ongoing basis.~~ The commissioner must not issue any new loans under this program after June 30, 2026.

Sec. 8. Minnesota Statutes 2025 Supplement, section 256.4792, subdivision 7, is amended to read:

Subd. 7. **Loan repayment.** (a) If a borrower is more than 60 calendar days delinquent in the timely payment of a contractual payment under this section, the provisions in paragraphs (b) to (e) apply.

(b) The commissioner may withhold some or all of the amount of the delinquent loan payment, together with any penalties due and owing on those amounts, from any money the department owes to the borrower. The commissioner may, at the commissioner's discretion, also withhold future contractual payments from any money the commissioner owes the provider as those contractual payments become due and owing. The commissioner may continue this withholding until the commissioner determines there is no longer any need to do so.

(c) The commissioner shall give prior notice of the commissioner's intention to withhold by mail, facsimile, or email at least ten business days before the date of the first payment period for which the withholding begins. The notice must be deemed received as of the date of mailing or receipt of the facsimile or electronic notice. The notice must state:

(1) the amount of the delinquent contractual payment;

(2) the amount of the withholding per payment period;

(3) the date on which the withholding is to begin;

(4) whether the commissioner intends to withhold future installments of the provider's contractual payments; and

(5) other contents as the commissioner deems appropriate.

(d) The commissioner, or the commissioner's designee, may enter into written settlement agreements with a provider to resolve disputes and other matters involving unpaid loan contractual payments or future loan contractual payments.

(e) Notwithstanding any law to the contrary, all unpaid loans, plus any accrued penalties, are overpayments for the purposes of section 256B.0641, subdivision 1. The current long-term services and supports provider is liable for the overpayment amount owed by a former owner for any provider sold, transferred, or reorganized.

(f) By January 15 each year, the commissioner must provide to the chairs and ranking minority members of the legislative committees with jurisdiction over nursing facilities a report of all facilities that are delinquent in their repayments. The reporting required under this paragraph expires upon notification by the commissioner to the committees that there are no outstanding balances from loan awards issued under this subdivision.

Sec. 9. Minnesota Statutes 2025 Supplement, section 256.4792, is amended by adding a subdivision to read:

Subd. 11. **Loan program expiration.** This section expires after the commissioner collects all loan repayments incurred on or before June 30, 2026. The commissioner must notify the revisor of statutes once all loan repayments under this section are collected.

Sec. 10. Minnesota Statutes 2024, section 256.975, subdivision 7b, is amended to read:

Subd. 7b. **Exemptions and emergency admissions.** (a) Exemptions from the federal screening requirements outlined in subdivision 7a, paragraphs (b) and (c), are limited to:

(1) a person who, having entered an acute care facility from a certified nursing facility, is returning to a certified nursing facility; or

(2) a person transferring from one certified nursing facility in Minnesota to another certified nursing facility in Minnesota.

(b) Persons who are exempt from preadmission screening for purposes of level of care determination include:

(1) persons described in paragraph (a);

(2) an individual who has a contractual right to have nursing facility care paid for indefinitely by the Veterans Administration; and

(3) an individual enrolled in a demonstration project under section 256B.69, subdivision 8, at the time of application to a nursing facility~~; and~~.

~~(4) an individual currently being served under the alternative care program or under a home and community-based services waiver authorized under section 1915(c) of the federal Social Security Act.~~

(c) Persons admitted to a Medicaid-certified nursing facility from the community on an emergency basis as described in paragraph (d) or from an acute care facility on a nonworking day must be screened the first working day after admission.

(d) Emergency admission to a nursing facility prior to screening is permitted when all of the following conditions are met:

(1) a person is admitted from the community to a certified nursing or certified boarding care facility during Senior LinkAge Line nonworking hours;

(2) a physician, advanced practice registered nurse, or physician assistant has determined that delaying admission until preadmission screening is completed would adversely affect the person's health and safety;

(3) there is a recent precipitating event that precludes the client from living safely in the community, such as sustaining an injury, sudden onset of acute illness, or a caregiver's inability to continue to provide care;

(4) the attending physician, advanced practice registered nurse, or physician assistant has authorized the emergency placement and has documented the reason that the emergency placement is recommended; and

(5) the Senior LinkAge Line is contacted on the first working day following the emergency admission.

(e) Transfer of a patient from an acute care hospital to a nursing facility is not considered an emergency except for a person who has received hospital services in the following situations: hospital admission for observation, care in an emergency room without hospital admission, or following hospital 24-hour bed care and from whom admission is being sought on a nonworking day.

(f) A nursing facility must provide written information to all persons admitted regarding the person's right to request and receive long-term care consultation services as defined in

section 256B.0911, subdivision 11. The information must be provided prior to the person's discharge from the facility and in a format specified by the commissioner.

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

Sec. 11. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision to read:

Subd. 28. **Interpretive guidelines for disability waiver regulation.** (a) The commissioner must develop and publish interpretive guidelines within 120 calendar days of the effective date of any statutory changes, waiver plan amendments, state or federal administrative rulings, or state or federal court decisions that affect policies or reimbursement for services licensed under chapter 245D, authorized under section 256B.092 or 256B.49, or reimbursed under section 256B.4914.

(b) Interpretive guidelines issued by the commissioner under this subdivision do not have the force and effect of law and have no precedential effect but may be relied on by consumers, providers of service, county agencies, the Department of Human Services, and others concerned until revoked or modified. An interpretive guideline may be expressly revoked or modified by the commissioner or by the issuance of another interpretive guideline but may not be revoked or modified retroactively to the detriment of consumers, providers of service, county agencies, the Department of Human Services, or others concerned. A change in the law or an interpretation of the law occurring after the interpretive guidelines are issued, whether in the form of a statute, court decision, administrative ruling, or subsequent interpretive guideline, results in the revocation or modification of the previously adopted guidelines to the extent that the change affects the guidelines.

EFFECTIVE DATE. This section is effective July 1, 2028, and applies to statutory changes, waiver plan amendments, state or federal administrative rulings, or state or federal court decisions effective or issued on or after that date.

Sec. 12. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision to read:

Subd. 29. **Certified assessor team.** The commissioner must employ certified assessors within the department to conduct assessments under section 256B.0911 on behalf of lead agencies under conditions and circumstances determined by the commissioner. Certified assessors employed by the commissioner may conduct assessments in addition to other duties as assigned, except the certified assessors employed by the commissioner must not perform any responsibilities of a lead agency described in section 256B.0911 other than

assessments. Nothing in this subdivision creates an obligation for the commissioner to provide the department's certified assessors to conduct assessments on behalf of a lead agency.

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

Sec. 13. Minnesota Statutes 2024, section 256B.0659, subdivision 12, is amended to read:

Subd. 12. **Documentation of personal care assistance services provided.** (a) Personal care assistance services for a recipient must be documented daily by each personal care assistant, on a time sheet form approved by the commissioner. All documentation may be web-based, electronic, or paper documentation. The completed form must be submitted on a monthly basis to the provider and kept in the recipient's health record.

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

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

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

(2) provider name and telephone numbers;

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

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

(5) signatures of recipient or the responsible party;

(6) personal signature of the personal care assistant;

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

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

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

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

Sec. 14. Minnesota Statutes 2024, section 256B.0659, subdivision 16, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) A qualified professional shall:

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2024, section 256B.0659, subdivision 17, is amended to read:

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

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

(c) The commissioner shall provide a rate system for shared ~~personal care assistance~~ services. For two ~~persons~~ recipients sharing services, the rate paid to a personal care assistance provider agency for the shared services must not exceed one and one-half times the rate paid for serving a single ~~individual, and~~ recipient. For three ~~persons~~ recipients sharing services, the rate paid to a personal care assistance provider agency for the shared services must not exceed twice the rate paid for serving a single ~~individual~~ recipient. These rates apply only when all ~~of the~~ criteria for ~~the~~ shared ~~care personal care assistance service have been~~ services are met.

(d) Of the additional revenue for shared services provided to two recipients, the personal care assistance provider agency must use 90 percent for the purposes specified in paragraph (e). Of the additional revenue for shared services provided to three recipients, the personal care assistance provider agency must use 90 percent for the purposes specified in paragraph (e).

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

Sec. 16. Minnesota Statutes 2024, section 256B.0659, subdivision 19, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 17. Minnesota Statutes 2025 Supplement, section 256B.0911, subdivision 30, is amended to read:

Subd. 30. **Assessment and support planning; supplemental information.** The lead agency must give the person receiving long-term care consultation services or the person's legal representative materials and forms supplied by the commissioner containing the following information:

(1) written recommendations for community-based services and consumer-directed options;

(2) documentation that the most cost-effective alternatives available were offered to the person;

(3) the need for and purpose of preadmission screening conducted by long-term care options counselors according to section 256.975, subdivisions 7a to 7c, if the person selects nursing facility placement. If the person selects nursing facility placement, the lead agency shall forward information needed to complete the level of care determinations and screening for developmental disability and mental illness collected during the assessment to the long-term care options counselor using forms provided by the commissioner;

(4) the role of long-term care consultation assessment and support planning in eligibility determination for waiver and alternative care programs and state plan home care, case management, and other services as defined in subdivision 11, clauses (7) to (10);

(5) information about Minnesota health care programs;

(6) the person's freedom to accept or reject the recommendations of the team;

(7) the person's right to confidentiality under the Minnesota Government Data Practices Act, chapter 13;

(8) the certified assessor's decision regarding the person's need for institutional level of care as determined under criteria established in subdivision 26 and regarding eligibility for all services and programs as defined in subdivision 11, clauses (7) to (10);

(9) the person's right to appeal the certified assessor's decision regarding eligibility for all services and programs as defined in subdivision 11, clauses (5), (7) to (10), and (15), and the decision regarding the need for institutional level of care~~, an attestation to no changes in needs or services,~~ or the lead agency's final decisions regarding public programs eligibility according to section 256.045, subdivision 3. The certified assessor must verbally communicate this appeal right to the person and must visually point out where in the document the right to appeal is stated; and

(10) documentation that available options for employment services, independent living, and self-directed services and supports were described to the person.

Sec. 18. Minnesota Statutes 2024, section 256B.0911, subdivision 32, as amended by Laws 2026, chapter 95, article 4, section 17, is amended to read:

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

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

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

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

<u>(4) effective July 1, 2028, grant limited role-based access to a person's support plan in the MnCHOICES system to home and community-based service providers who have been designated as a provider for that person by a lead agency for the purpose of signing the person's support plan electronically and demonstrating that the provider has reviewed, understood, and agrees to deliver services as outlined in the plan.</u>

(b) The commissioner shall work with lead agencies responsible for conducting long-term care consultation services to modify the MnCHOICES application and assessment policies

to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria.

Sec. 19. Minnesota Statutes 2024, section 256B.0922, is amended by adding a subdivision to read:

Subd. 3. **Billing limits.** (a) Effective January 1, 2027, or upon federal approval, whichever is later, billable unit maximums are established for the following services authorized under this section:

(1) for chore services, a maximum of 24 units per week per recipient, where a unit is defined as a 15-minute increment;

(2) for homemaker services, cleaning and home management may be provided for a maximum of 16 hours combined per week per recipient; and

(3) for personal emergency response system services, a maximum of one unit per month per recipient.

(b) Billing limits under this subdivision apply only to the individual service listed and do not prohibit the recipient from accessing other services for which they are eligible on the same day, week, or month, subject to other applicable requirements.

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

Sec. 20. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision to read:

Subd. 20. **Billing limits.** (a) Effective July 1, 2027, or upon federal approval, whichever is later, the following billing limits apply to early intensive developmental and behavioral intervention services:

(1) intensive services: 40 hours per week per recipient;

(2) travel: two hours per day per recipient;

(3) observation and direction: 20 hours per week per recipient; and

(4) individual treatment and planning: 300 units per year per recipient.

(b) The commissioner must grant exceptions to the billing limits under paragraph (a) when services in excess of the billing limits are determined to be medically necessary. A provider must apply to the commissioner for an exception on the forms and in the manner

prescribed by the commissioner. A determination under this paragraph is final and not subject to appeal.

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

Sec. 21. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision to read:

Subd. 17. **Billing limits.** (a) Effective January 1, 2027, or upon federal approval, whichever is later, billable unit maximums are established for the following services authorized under sections 256B.092 and 256B.49:

(1) for assistive technology authorized under section 256B.092, a maximum of $10,000 annually per recipient;

(2) for chore services, a maximum of 24 units per week per recipient, where a unit is defined as a 15-minute increment;

(3) for homemaker services, cleaning and home management may be provided for a maximum of 16 hours combined per week per recipient;

(4) for family training and counseling, a maximum of two hours per week per recipient;

(5) for independent living skills, a maximum of six hours per day per recipient; and

(6) for personal emergency response system services, a maximum of one unit per month per recipient.

(b) The limits in this subdivision do not limit a person's use of other waiver services. Billing limits under this subdivision apply only to the individual service listed and do not prohibit the recipient from accessing other services for which they are eligible on the same day, week, or month, subject to other applicable requirements.

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

Sec. 22. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision to read:

Subd. 18. **Prohibition on room and board payments.** (a) The provider must not use medical assistance money to pay for room and board, including but not limited to rent, mortgage payments, utilities, property taxes, homeowners association fees, or any other housing-related cost, in accordance with federal home and community-based services waiver requirements under United States Code, title 42, section 1396n(c), and Code of Federal Regulations, title 42, section 441.310.

(b) A provider of home and community-based services, including but not limited to integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause (8), must not:

(1) use, allocate, or apply any payment for home and community-based services to cover, subsidize, discount, or otherwise contribute to any room and board expenses for a person receiving services;

(2) apply agency operating margins, reserves, or profits derived from home and community-based services to pay for rent or pay other housing costs for persons receiving services; or

(3) enter into any financial arrangement, discount, concession, or reimbursement structure that has the effect of using medical assistance service revenue to offset the housing costs of a person receiving services.

(c) Nothing in this subdivision prohibits a provider from charging a person for room and board in accordance with chapter 504B or applicable housing support laws, provided the charge is independent of medical assistance payments and complies with all federal home and community-based services setting requirements, including but not limited to tenancy protections under Code of Federal Regulations, title 42, section 441.301(c)(4)(vi)(A).

(d) The commissioner may pursue corrective action, payment recovery, sanctions under section 256B.064, and licensing action under chapter 245A or 245D for a violation of this subdivision.

(e) Notwithstanding paragraphs (a) and (b), payment for room and board is permitted when explicitly included as part of a service authorized in a federally approved home and community-based services waiver under United States Code, title 42, section 1396n(c).

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

Sec. 23. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 3, is amended to read:

Subd. 3. **Applicable services.** Applicable services are those authorized under the state's home and community-based services waivers under sections 256B.092 and 256B.49, including the following, as defined in the federally approved home and community-based services plan:

(1) 24-hour customized living;

(2) adult day services;

(3) adult day services bath;

(4) community residential services;

(5) customized living;

(6) day support services;

(7) employment development services;

(8) employment exploration services;

(9) employment support services;

(10) family residential services;

(11) individualized home supports;

(12) individualized home supports with family training;

(13) individualized home supports with training;

(14) integrated community supports;

(15) life sharing;

(16) effective until the effective date of clauses (17) and (18), night supervision;

(17) effective January 1, 2026, or upon federal approval, whichever is later, awake night supervision;

(18) effective January 1, 2026, or upon federal approval, whichever is later, asleep night supervision;

(19) positive support services;

(20) prevocational services;

(21) residential support services;

(22) transportation services;

(23) effective October 1, 2027, or upon federal approval, whichever is later, integrated community supports access services; and

~~(23)~~ (24) other services as approved by the federal government in the state home and community-based services waiver plan.

Sec. 24. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 5a, is amended to read:

Subd. 5a. **Base wage index; calculations.** The base wage index must be calculated as follows:

(1) for supervisory staff, 100 percent of the median wage for community and social services specialist (SOC code 21-1099), with the exception of the supervisor of positive supports professional, positive supports analyst, and positive supports specialist, which is 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(2) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC code 29-1141);

(3) for licensed practical nurse staff, 100 percent of the median wage for licensed practical nurses (SOC code 29-2061);

(4) for residential asleep-overnight staff, the minimum wage in Minnesota for large employers;

(5) for residential direct care staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); 30 percent of the median wage for nursing assistant (SOC code 31-1131); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(6) for adult day services staff, 70 percent of the median wage for nursing assistant (SOC code 31-1131); and 30 percent of the median wage for home health and personal care aide (SOC code 31-1120);

(7) for day support services staff and prevocational services staff, 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social and human services aide (SOC code 21-1093);

(8) for positive supports analyst staff, 100 percent of the median wage for substance abuse, behavioral disorder, and mental health counselor (SOC code 21-1018);

(9) for positive supports professional staff, 100 percent of the median wage for clinical counseling and school psychologist (SOC code 19-3031);

(10) for positive supports specialist staff, 100 percent of the median wage for psychiatric technicians (SOC code 29-2053);

(11) for individualized home supports with family training staff, 20 percent of the median wage for nursing aide (SOC code 31-1131); 30 percent of the median wage for community social service specialist (SOC code 21-1099); 40 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(12) for individualized home supports with training services staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053);

(13) for employment support services staff, 50 percent of the median wage for rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(14) for employment exploration services staff, 50 percent of the median wage for education, guidance, school, and vocational counselor (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(15) for employment development services staff, 50 percent of the median wage for education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent of the median wage for community and social services specialist (SOC code 21-1099);

(16) for individualized home support without training staff, 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); and 50 percent of the median wage for nursing assistant (SOC code 31-1131);

(17) effective until the effective date of clauses (18) and (19), for night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(18) effective January 1, 2026, or upon federal approval, whichever is later, for awake night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 of percent the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aid (SOC code 21-1093); ~~and~~

(19) effective January 1, 2026, or upon federal approval, whichever is later, for asleep night supervision staff, the minimum wage in Minnesota for large employers; and

(20) effective October 1, 2027, or upon federal approval, whichever is later, for integrated community support staff, the sum of:

(i) 15 percent of the subtotal of 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); 30 percent of the median wage for nursing assistant (SOC code 31-1131); and 20 percent of the median wage for social and human services aide (SOC code 21-1093); and

(ii) 85 percent of the subtotal of 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093).

Sec. 25. Minnesota Statutes 2024, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Residential support services; generally.** (a) For purposes of this section, residential support services includes 24-hour customized living services, community residential services, customized living services, and integrated community supports.

(b) Effective October 1, 2027, or upon federal approval, whichever is later, for purposes of this section, residential support services includes 24-hour customized living services, community residential services, customized living services, and integrated community supports access services.

~~(b)~~ (c) A unit of service for residential support services is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day. The number of days authorized for all individuals enrolling in residential support services must include every day that services start and end.

~~(c)~~ (d) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential support services after January 1, 2014, then individual staffing hours shall be used.

Sec. 26. Minnesota Statutes 2024, section 256B.4914, subdivision 6a, is amended to read:

Subd. 6a. **Community residential services; component values and calculation of payment rates.** (a) Component values for community residential services are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(b) Payments for community residential services must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs provided on site or through monitoring technology;

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

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

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

(5) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the appropriate staff wages;

(6) multiply the number of shared direct staffing and individual direct staffing hours provided on site or through monitoring technology and nursing hours by the product of the supervision span of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

(7) combine the results of clauses (5) and (6), excluding any shared direct staffing and individual direct staffing hours provided through monitoring technology, and multiply the result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost, excluding any shared direct staffing and individual hours provided through monitoring technology, by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) for transportation, if provided, add $1,742.62 divided by 365, or $3,111.81 divided by 365 if customized for adapted transport, based on the resident with the highest assessed need. The commissioner shall update the amounts in this clause as specified in subdivision 5b;

(11) subtotal clauses (8) to (10) and the direct staffing cost of any shared direct staffing and individual direct staffing hours provided through monitoring technology that was excluded in clause (8);

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

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

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(c) Effective July 1, 2027, the commissioner must establish the following acuity-based community residential service tool input limits on total individual hours entered, based on the case mix rates determined under this section:

(1) zero individual hours per day for people assessed for case mixes A, C, and L;

(2) no more than six individual hours per day for people assessed for case mixes B, D, and F;

(3) no more than 16 individual hours per day for people assessed for case mixes E, G, I, J, and K; and

(4) no more than 24 individual hours per day for people assessed for case mix H or residing in a community residential setting licensed for one person regardless of case mix level.

(d) The commissioner must provide an exception process under subdivision 14 to the limits in paragraph (c) for individuals with extraordinary needs who might otherwise end up in institutional settings without additional authorized individual hour inputs.

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

Sec. 27. Minnesota Statutes 2024, section 256B.4914, subdivision 6c, is amended to read:

Subd. 6c. **Integrated community supports; component values and calculation of payment rates.** (a) Component values for integrated community supports are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(b) Payments for integrated community supports must be calculated as follows:

(1) determine the number of shared direct staffing and individual direct staffing hours to meet a recipient's needs. The base shared direct staffing hours must be eight hours divided by the ~~number of people receiving support in~~ approved capacity of the integrated community support setting, and the individual direct staffing hours must be the average number of direct support hours provided directly to the service recipient;

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

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

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

(5) multiply the number of shared direct staffing and individual direct staffing hours in clause (1) by the appropriate staff wages;

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

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

(8) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) add the results of clauses (8) and (9);

(11) add the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(c) The commissioner must establish maximum allowable in-person and remote service hours used in the rate methodology for integrated community supports based on the recipient's case mix classification. Effective January 1, 2027, the total number of service hours entered into the rate framework must not exceed the following limits:

(1) for case mix classifications A, C, and L, a maximum of two hours per day;

(2) for case mix classifications B, D, and F, a maximum of four hours per day;

(3) for case mix classifications E, G, I, J, and K, a maximum of six hours per day; and

(4) for case mix classification H, a maximum of eight hours per day.

(d) The daily limit in paragraph (c) does not limit a person's use of other disability waiver services that may be provided on the same day in alignment with the federally approved waiver. Nothing in paragraph (c) prohibits approval of a rate exception for individuals with exceptional or complex needs.

(e) This subdivision expires upon the effective date of subdivisions 6e and 8a.

Sec. 28. Minnesota Statutes 2024, section 256B.4914, subdivision 6d, is amended to read:

Subd. 6d. **Payment for customized living.** (a) The payment methodology for customized living and 24-hour customized living must be the customized living tool. The commissioner shall revise the customized living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.

(b) The rate adjustments described in section 256S.205 do not apply to rates paid under this section.

(c) Customized living and 24-hour customized living rates determined under this section shall not include more than 24 hours of support in a daily unit.

(d) The commissioner shall establish the following acuity-based customized living tool input limits, based on case mix, for customized living and 24-hour customized living rates determined under this section:

(1) no more than two hours of mental health management per day for people assessed for case mixes A, D, and G;

(2) no more than four hours of activities of daily living assistance per day for people assessed for case mix B; and

(3) no more than six hours of activities of daily living assistance per day for people assessed for case mix D.

(e) Effective January 1, 2027, or upon federal approval, whichever is later, customized living monthly service rate limits must equal the monthly service rate limits determined under section 256S.202, subdivisions 1 and 2, multiplied by 126.36 percent.

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

Sec. 29. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 6e. **Integrated community supports access services; component values and calculation of payment rates.** (a) This subdivision is effective October 1, 2027, or upon federal approval, whichever is later.

(b) Component values for integrated community supports access services are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 1.3 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(c) Payments for integrated community supports access services must be calculated as follows:

(1) the base shared direct staffing hours must be eight hours divided by the approved capacity of integrated community support setting;

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

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

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

(5) multiply the number of shared direct staffing hours in clause (1) by the appropriate staff wages;

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

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

(8) for employee-related expenses, multiply the direct staffing cost by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) add the results of clauses (8) and (9);

(11) add the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(12) divide the result of clause (10) by one minus the result of clause (11). This is the total payment amount; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing residential services.

Sec. 30. Minnesota Statutes 2024, section 256B.4914, subdivision 7b, is amended to read:

Subd. 7b. **Day support services; component values and calculation of payment rates.** (a) Component values for day support services are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 5.6 percent;

(6) client programming and support ratio: 10.37 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.8 percent; and

(9) absence and utilization factor ratio: 9.4 percent.

(b) A unit of service for day support services is 15 minutes.

(c) Payments for day support services must be calculated as follows:

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

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

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

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

(5) multiply the number of day program direct staffing hours and nursing hours by the appropriate staff wage;

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

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

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

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

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

(11) for program facility costs, add $19.30 per week with consideration of staffing ratios to meet individual needs, updated as specified in subdivision 5b;

(12) this is the subtotal rate;

(13) sum the standard general administrative rate support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(14) divide the result of clause (12) by one minus the result of clause (13). This is the total payment amount; and

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

(d) Effective January 1, 2027, or upon federal approval, whichever is later, the billing limit for day support services is equal to a maximum of eight hours per day per recipient.

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

Sec. 31. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 8, is amended to read:

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

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

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 15.5 percent;

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

(7) general administrative support ratio: 13.25 percent;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

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

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

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

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

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

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

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

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

(1) for individualized home supports with training, a monthly service limit of 182.5 hours; and

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

(g) The limits in paragraph (f), clauses (1) and (2), do not limit a person's use of other disability waiver services, including individualized home supports, which may be provided on the same day by the same provider providing individualized home supports with training or individualized home supports with family training.

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

Sec. 32. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 8a. **Integrated community supports unit-based services with programming; component values and calculation of payment rates.** (a) This subdivision is effective October 1, 2027, or upon federal approval, whichever is later.

(b) Component values for integrated community supports unit-based services with programming are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 11.25 percent;

(6) client programming and support ratio: 3.5 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 1.3 percent; and

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

(c) A unit of integrated community supports unit-based services with programming is 15 minutes.

(d) Payments for integrated community supports unit-based services must be calculated as follows:

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing residential services.

(e) The commissioner must establish maximum allowable in-person and remote service hours used in the rate methodology for integrated community supports based on the recipient's case mix classification. The total number of service hours entered into the rate framework must not exceed the following limits:

(1) for case mix classifications A, C, and L, a maximum of two hours per day;

(2) for case mix classifications B, D, and F, a maximum of four hours per day;

(3) for case mix classifications E, G, I, J, and K, a maximum of six hours per day; and

(4) for case mix classification H, a maximum of eight hours per day.

(f) The daily limit in paragraph (e) does not limit a person's use of other disability waiver services that may be provided on the same day in alignment with the federally approved waiver. Nothing in paragraph (e) prohibits approval of a rate exception for individuals with exceptional or complex needs.

Sec. 33. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 9, is amended to read:

Subd. 9. **Unit-based services without programming; component values and calculation of payment rates.** (a) For the purposes of this section, unit-based services without programming include individualized home supports without training and night supervision provided to an individual outside of any service plan for a day program or residential support service. Unit-based services without programming do not include respite. This paragraph expires upon the effective date of paragraph (b).

(b) Effective January 1, 2026, or upon federal approval, whichever is later, for the purposes of this section, unit-based services without programming include individualized

home supports without training, awake night supervision, and asleep night supervision provided to an individual outside of any service plan for a day program or residential support service.

(c) Component values for unit-based services without programming are:

(1) competitive workforce factor: 6.7 percent;

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

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

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

(5) program plan support ratio: 7.0 percent;

(6) client programming and support ratio: 2.3 percent, updated as specified in subdivision 5b;

(7) general administrative support ratio: 13.25 percent;

(8) program-related expense ratio: 2.9 percent; and

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

(d) A unit of service for unit-based services without programming is 15 minutes.

(e) Payments for unit-based services without programming must be calculated as follows unless the services are reimbursed separately as part of a residential support services or day program payment rate:

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

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

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

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

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

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

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

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

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

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

(11) this is the subtotal rate;

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

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

(14) for individualized home supports without training provided in a shared manner, divide the total payment amount in clause (13) by the number of service recipients, not to exceed three; and

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

(f) Effective January 1, 2027, or upon federal approval, whichever is later, the billing limit for awake night supervision and asleep night supervision is equal to a maximum of ten hours per day per recipient, of which no more than eight hours per day may be asleep night supervision.

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

Sec. 34. Minnesota Statutes 2024, section 256B.4914, subdivision 9a, is amended to read:

Subd. 9a. **Respite services; component values and calculation of payment rates.** (a) For the purposes of this section, respite services include respite services provided to an individual outside of any service plan for a day program or residential support service.

(b) Component values for respite services are:

(1) competitive workforce factor: 4.7 percent;

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

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

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

(5) general administrative support ratio: 13.25 percent;

(6) program-related expense ratio: 2.9 percent; and

(7) absence and utilization factor ratio: 3.9 percent.

(c) A unit of service for respite services is 15 minutes.

(d) Payments for respite services must be calculated as follows unless the service is reimbursed separately as part of a residential support services or day program payment rate:

(1) determine the number of units of service to meet an individual's needs;

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

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

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

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

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

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

(8) for employee-related expenses, multiply the result of clause (7) by one plus the employee-related cost ratio;

(9) this is the subtotal rate;

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

(11) divide the result of clause (9) by one minus the result of clause (10). This is the total payment amount;

(12) for respite services provided in a shared manner, divide the total payment amount in clause (11) by the number of service recipients, not to exceed three; and

(13) adjust the result of clause (12) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

(e) Effective January 1, 2027, or upon federal approval, whichever is later, the billing limit for in-home respite services is equal to a maximum of 30 consecutive days per respite occurrence.

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

Sec. 35. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 10e. **Documentation of staffing; auditing and rate review.** (a) Effective for services provided on or after January 1, 2029, a provider enrolled to provide residential support services under subdivision 6 must maintain documentation of direct staffing hours provided to each person receiving services, including but not limited to documentation identifying:

(1) the name, role, and unique identifier for each staff person who provided services to match records to payroll, time and attendance systems, and any other source documentation;

(2) the date services were provided;

(3) the total number of hours of direct support provided;

(4) awake overnight staffing hours provided, if applicable;

(5) asleep overnight staffing hours provided, if applicable; and

(6) any other staffing information required by the commissioner.

(b) A provider must maintain documentation in a manner and format determined by the commissioner for at least six years. If a provider changes payroll vendors, merges operations, or changes staffing identifiers, the provider must maintain a documented link between prior and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and role classification for each staff person.

(c) A provider must submit the documentation required under paragraph (a) to the commissioner annually, in a manner and format determined by the commissioner. The commissioner must establish multiple submission windows throughout the calendar year and may assign providers to a submission window for administrative efficiency and system capacity. Documentation must reflect staffing provided during the prior calendar year and must be submitted no later than the final business day of the provider's assigned submission window. The commissioner may conduct random or targeted validations and audits of

submitted data and may require supplemental documentation as necessary to verify accuracy and compliance.

(d) The commissioner must conduct periodic analysis of documentation submitted under this subdivision and may validate staffing data through random audits or other verification methods.

(e) Based on the analysis under paragraph (d), the commissioner may provide recommendations to lead agencies regarding modifications to the rate of a person receiving services, including increases or decreases necessary to align the rate with staffing provided to the person as demonstrated by the submitted historical staffing documentation. Recommendations must be based on the requirements of this section and applicable federal and state requirements governing rate setting.

(f) If a provider fails to submit documentation requested within the submission window in paragraph (c), the commissioner must issue a written notice of noncompliance. If documentation is not received within 60 days following the notice of noncompliance, the commissioner may temporarily suspend payments to the provider until the required documentation is submitted. The commissioner must make withheld payments to the provider once the required documentation is received. If the noncompliance persists, the commissioner may adjust future rate payments, require the provider to submit a corrective action plan, or pursue other enforcement actions as authorized by law.

(g) The commissioner must publish annual aggregate reports summarizing audit findings and trends related to staffing provided under this section.

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

Sec. 36. Minnesota Statutes 2024, section 256B.4914, subdivision 13, is amended to read:

Subd. 13. **Transportation.** The commissioner shall require that the purchase of transportation services be cost-effective and be limited to market rates where the transportation mode is generally available and accessible. Effective January 1, 2027, or upon federal approval, whichever is later, the billing limit for waiver transportation is equal to a maximum of 28 one-way trips per week per participant.

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

Sec. 37. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 21. **Integrated community supports access services; service standards and billing criteria.** (a) This subdivision is effective October 1, 2027, or upon federal approval, whichever is later.

(b) For the purposes of this section, "integrated community supports access services" means the onsite or on-call availability of trained staff to address an individual's incidental, unplanned support needs in an integrated community supports setting.

(c) A provider billing integrated community supports access services for on-call staff must ensure that on-call staff are only assigned to one setting and can respond in-person to the setting within 30 minutes of receiving a request for support. A provider must ensure that staff providing onsite or on-call availability are specifically trained to support the individual for each integrated community supports access services unit billed.

(d) Providers must collect and maintain documentation on each instance of incidental, unplanned support provided to an individual by onsite or on-call staff. A documented instance of staff providing incidental, unplanned support is not required for each day the integrated community supports access services unit is billed.

(e) Documentation required under this subdivision must include:

(1) the individual's name;

(2) the date and time the individual requested incidental, unplanned support from onsite or on-call staff;

(3) the date and time of the incidental, unplanned support provision;

(4) the name of the staff member providing the incidental, unplanned support;

(5) a description of what incidental, unplanned support was provided; and

(6) an indication if provision of incidental, unplanned support did or did not result in the need for direct one-to-one support billed under subdivision 8a.

(f) A provider must document each instance of incidental, unplanned support provision within 72 hours. If documentation is completed more than 72 hours after provision of incidental, unplanned support, the provider must document extenuating circumstances that resulted in the delay in documentation under this subdivision.

(g) Documentation must be maintained either electronically or in paper form. The provider must produce the documentation upon request by the commissioner or lead agency.

Sec. 38. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 22. **Administrative fees charged by providers and vendors.** Effective July 1, 2027, or upon federal approval, whichever is later, the commissioner must limit administrative fees charged by enrolled providers and vendors approved by lead agencies to no more than six percent of the total cost of the service or purchased goods. This limit applies to the following services and other new market rate services as determined by the commissioner:

(1) chore services billed daily;

(2) transitional services; and

(3) transportation.

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

Sec. 39. Minnesota Statutes 2024, section 256B.492, is amended by adding a subdivision to read:

Subd. 4. **Integrated community supports setting approval moratorium and exception.** (a) For purposes of this subdivision, "integrated community supports setting" means a multifamily housing building where a provider delivers integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause (8), and for which a provider has a provider-controlled or provider-associated financial interest as defined under section 245A.02, subdivision 10b.

(b) The commissioner must not approve a new integrated community supports setting or approve an expansion of an existing integrated community supports setting except as provided in this subdivision.

(c) The commissioner may approve an exception to the moratorium only when the applicant demonstrates indirect control of the setting and compliance with:

(1) the federal home and community-based services requirements under Code of Federal Regulations, title 42, section 441.301(c);

(2) the prohibition on the use of medical assistance money for room and board under section 256B.4912, subdivision 17;

(3) independent lease requirements consistent with chapter 504B; and

(4) all documentation requirements under section 245D.12.

(d) To approve an exception, the commissioner must determine that the lead agency has requested the additional capacity to meet the specific disability-related needs of the person. Priority must be given to geographic regions with insufficient integrated community supports capacity based on statewide or regional needs determination processes.

(e) Nothing in this subdivision authorizes the commissioner to revoke approval of a previously approved setting following a change of ownership permissible under section 245A.043.

(f) A determination under this subdivision is final and not subject to appeal.

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

Sec. 40. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 7, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 7d. **Shared services rates under the agency-provider model.** The commissioner shall provide a rate system for shared services. For two participants sharing services, the rate paid to an agency-provider for the shared services must not exceed one and one-half

times the rate paid for serving a single participant. For three participants sharing services, the rate paid to an agency-provider for the shared services must not exceed twice the rate paid for serving a single participant. These rates apply only when all criteria for shared services are met.

Sec. 43. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision to read:

Subd. 7e. **Pass-through for shared services under the agency-provider model.** (a) Of the additional revenue for shared services provided to two participants, the agency-provider must use 90 percent for the purposes specified in paragraph (b). Of the additional revenue for shared services provided to three participants, the agency-provider must use 90 percent for the purposes specified in paragraph (b).

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

Sec. 44. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision to read:

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

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

(c) The participants, or participants' representatives as needed, who elect to share services under the budget model must jointly develop a shared services agreement with the support

of the participants' representatives as needed. Any participant or any participant's representative may at any time withdraw from participating in a shared services agreement.

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

Sec. 45. Minnesota Statutes 2024, section 256B.85, is amended by adding a subdivision to read:

Subd. 7g. **Pass-through for shared services under the budget model.** For shared services provided under the budget model, participant employers must pay the individual provider support worker providing the shared services a percentage of the minimum wage specified in the agreement negotiated under chapter 179A, as made applicable to individual providers under section 179A.54, that is in effect at the time the services are provided. The required percentages are specified in clauses (1) and (2):

(1) for shared services provided by an individual provider support worker to two participant employers, the two participant employers must collectively pay the individual provider support worker at least 150 percent of the applicable minimum wage; and

(2) for shared services provided by an individual provider support worker to three participant employers, the three participant employers must collectively pay the individual support worker at least 200 percent of the applicable minimum wage.

Sec. 46. **[256B.8502] COMMUNITY FIRST SERVICES AND SUPPORTS; DEFINITIONS.**

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

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

Subd. 3. **Individual provider support worker.** "Individual provider support worker" means a support worker who is an individual provider as defined in section 256B.0711, subdivision 1.

Subd. 4. **Wages and wage-related costs.** "Wages and wage-related costs" means increased wages and any corresponding increase in the employer's or participant employer's share of FICA taxes, Medicare taxes, state and federal unemployment taxes, workers'

compensation premiums, and contributions to employee retirement accounts when the contribution is a function of wages.

Sec. 47. **[256R.60] NURSING FACILITY WORKFORCE WAGE SUPPLEMENT PROGRAM.**

Subdivision 1. **Program established.** The commissioner must establish a program to provide supplemental wage payments to nursing home employees as provided in this section.

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

(b) "Commissioner" means the commissioner of human services.

(c) "Covered employee" means a nursing home worker, as defined in section 181.211, subdivision 9, who worked at least 260 hours for a covered employer between January 1, 2026, and June 30, 2026.

(d) "Covered employer" means a nursing home employer as defined in section 181.211, subdivision 8.

Subd. 3. **Eligibility for supplemental wage payments.** (a) A covered employee is eligible to receive a onetime payment of up to $400 if, during the period from January 1, 2026, to June 30, 2026, the employee was:

(1) in a position impacted by the January 1, 2026, wage standards described by Minnesota Rules, parts 5200.2060 to 5200.2090; and

(2) paid at an hourly wage that was less than the applicable January 1, 2026, wage standards described by Minnesota Rules, parts 5200.2060 to 5200.2090.

(b) A covered employee who does not meet the criteria in paragraph (a) is eligible to receive a onetime payment of up to $200.

(c) If appropriations are not sufficient to provide the maximum payment amount for all approved applications, the commissioner must first ensure payments are distributed in an equal amount, up to $400, to all approved applicants meeting the criteria in paragraph (a).

(d) If additional funding exists after making payments under paragraph (c), the commissioner must use the additional funding available to distribute payments in an equal amount, up to $200, to all covered employees not meeting the criteria in paragraph (a).

Subd. 4. **Employee and wage reporting by covered employees.** (a) A covered employer must, by July 31, 2026, provide the commissioner with wage and hour data for the January

1, 2026, to June 30, 2026, period for each covered employee in a form and manner determined by the commissioner.

(b) The commissioner may request additional information from covered employers to validate the data provided under paragraph (a). A covered employer must respond to requests from the commissioner under this paragraph.

(c) A covered employer that fails to comply with this subdivision may be subject to payment reduction under section 256R.09, subdivision 4.

Subd. 5. **Application and payment processes.** (a) As soon as practicable after final enactment of this act, the commissioner must establish a process for accepting applications for payments under this section and begin accepting applications.

(b) The commissioner must:

(1) establish a multilingual temporary help line for applicants; and

(2) offer multilingual applications and multilingual instructions.

(c) To qualify for a payment under this section, a covered employee must submit an application in a form and manner determined by the commissioner. As part of the application, an applicant must certify to the commissioner that the applicant is a covered employee and is eligible for payment under this section.

(d) The commissioner may contract with a third party to implement part or all of the application and payment processes required under this section.

(e) The commissioner's determination of eligibility for payments and amounts is final and is not subject to appeal.

(f) No later than 15 days after the application period is opened under this subdivision, covered employers must provide notice, in a form and manner approved by the commissioner, advising all current employees who may be eligible for payments under this section of the assistance potentially available to them and how to apply for benefits. A covered employer must provide notice using the same means the covered employer uses to provide other work-related notices to employees.

(g) Notice provided under paragraph (f) must be at least as conspicuous as:

(1) posting a copy of the notice at each work site where employees work and where the notice may be readily observed and reviewed by all employees working at the site; or

(2) providing a paper or electronic copy of the notice to all employees.

Subd. 6. **Audits and recoupment.** (a) The commissioner may perform an audit under this section up to six years after a payment is awarded to ensure that:

(1) the covered employee was eligible to receive payment under this section; and

(2) the covered employee received payments only in the amount permitted under this section.

(b) If the commissioner determines that a covered employee received payments not in compliance with this section, the commissioner must attempt to recoup the payment.

Subd. 7. **Payments not to be considered income.** (a) Notwithstanding any law to the contrary, payments provided under this section must not be considered income, assets, or personal property for purposes of determining eligibility or recertifying eligibility for:

(1) child care assistance programs under chapter 142E;

(2) general assistance and Minnesota supplemental aid under chapter 256D;

(3) food support under chapter 142F;

(4) housing support under chapter 256I;

(5) the Minnesota family investment program and diversionary work program under chapter 142G; and

(6) economic assistance programs under chapter 256P.

(b) The commissioner must not consider grant awards under this section as income or assets under section 256B.056, subdivision 1a, paragraph (a); 3; or 3c, or for persons with eligibility determined under section 256B.057, subdivision 3, 3a, 3b, 4, or 9.

Subd. 8. **Expiration.** This section expires June 30, 2028.

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

Sec. 48. Minnesota Statutes 2024, section 256S.15, is amended by adding a subdivision to read:

Subd. 3. **Billing limits.** (a) Effective January 1, 2027, or upon federal approval, whichever is later, billable unit maximums are established for the following services authorized under section 256B.0913 and this chapter:

(1) for adult companion services, a maximum of six hours per day per recipient and a maximum of 936 hours annually per recipient;

(2) for chore services, a maximum of 24 units per week per recipient, where a unit is defined as a 15-minute increment;

(3) for homemaker services, cleaning and home management may be provided for a maximum of 16 hours combined per week per recipient;

(4) for personal emergency response system services, a maximum of one unit per month per recipient; and

(5) for waiver transportation, a maximum of 28 one-way trips per week per participant.

(b) The limits in this subdivision do not limit a person's use of other waiver services. Billing limits under this subdivision apply only to the individual service listed and do not prohibit the recipient from accessing other services for which they are eligible on the same day, week, or month, subject to other applicable requirements.

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

Sec. 49. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision to read:

Subd. 4. **Documentation of staffing; auditing and rate review for residential support services.** (a) For purposes of this subdivision, residential support services include 24-hour customized living services, customized living services, family adult foster care, and corporate adult foster care.

(b) Effective January 1, 2029, a provider enrolled to provide residential support services under this subdivision must maintain documentation of direct staffing hours provided to each person receiving services, including but not limited to documentation identifying:

(1) the name, role, and unique identifier for each staff person who provided services to match records to payroll, time and attendance systems, and any other source documentation;

(2) the date services were provided;

(3) the total number of hours of direct support provided;

(4) awake overnight staffing hours provided, if applicable;

(5) asleep overnight staffing hours provided, if applicable; and

(6) any other staffing information required by the commissioner.

(c) A provider must maintain documentation in a manner and format determined by the commissioner for at least six years. If a provider changes payroll vendors, merges operations, or changes staffing identifiers, the provider must maintain a documented link between prior

and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and role classification for each staff person.

(d) A provider must submit the documentation required under paragraph (b) to the commissioner annually, in a manner and format determined by the commissioner. The commissioner must establish multiple submission windows throughout the calendar year and may assign providers to a submission window for administrative efficiency and system capacity. Documentation must reflect staffing provided during the prior calendar year and must be submitted no later than the final business day of the provider's assigned submission window. The commissioner may conduct random or targeted validations and audits of submitted data and may require supplemental documentation as necessary to verify accuracy and compliance.

(e) The commissioner must conduct periodic analysis of documentation submitted under this subdivision and may validate staffing data through random audits or other verification methods.

(f) Based on the analysis under paragraph (e), the commissioner may provide recommendations to lead agencies regarding modifications to the rate of the person receiving services, including increases or decreases necessary to align the rate with staffing provided to the person as demonstrated by the submitted historical staffing documentation. Recommendations must be based on the requirements of this section and applicable federal and state requirements governing rate setting.

(g) If a provider fails to submit documentation requested within the submission window under paragraph (d), the commissioner must issue a written notice of noncompliance. If documentation is not received within 60 days following the notice of noncompliance, the commissioner may temporarily suspend payments to the provider until the required documentation is submitted. The commissioner must make withheld payments to the provider once the required documentation is received. If the noncompliance persists, the commissioner may adjust future rate payments, require the provider to submit a corrective action plan, or pursue other enforcement actions as authorized by law.

(h) The commissioner must publish annual aggregate reports summarizing audit findings and trends related to staffing provided under this section.

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

Sec. 50. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision to read:

Subd. 5. **Administrative fees charged by providers or vendors.** The commissioner must limit administrative fees charged by enrolled providers or vendors approved by lead agencies to no more than six percent of the total cost of the service or purchased goods. This limit applies to the following services but allows for the addition of other services determined by the commissioner:

(1) chore services billed daily;

(2) transitional services; and

(3) transportation.

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

Sec. 51. Laws 2021, First Special Session chapter 7, article 13, section 73, as amended by Laws 2025, First Special Session chapter 9, article 2, section 56, is amended to read:

Sec. 73. **WAIVER REIMAGINE PHASE II.**

(a) Effective January 1, 2027, or upon federal approval, whichever is later, the commissioner of human services must implement a two-home and community-based services waiver program structure, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(b) The commissioner of human services must implement an individualized budget methodology, as authorized under section 1915(c) of the federal Social Security Act, that serves persons who are determined by a certified assessor to require the levels of care provided in a nursing home, a hospital, a neurobehavioral hospital, or an intermediate care facility for persons with developmental disabilities.

(c) The commissioner must develop an individualized budget methodology exception to support access to self-directed home care nursing services. Lead agencies must submit budget exception requests to the commissioner in a manner identified by the commissioner. Eligibility for the budget exception in this paragraph is limited to persons meeting all of the following criteria in the person's most recent assessment:

(1) the person is assessed to need the level of care delivered in a hospital setting as evidenced by the submission of the Department of Human Services form 7096, primary medical provider's documentation of medical monitoring and treatment needs;

(2) the person is assessed to receive a support range budget of E or H; and

(3) the person does not receive community residential services, family residential services, integrated community supports services, or customized living services.

(d) Home care nursing services funded through the budget exception developed under paragraph (c) must be ordered by a physician, physician assistant, or advanced practice registered nurse. If the participant chooses home care nursing, the home care nursing services must be performed by a registered nurse or licensed practical nurse practicing within the registered nurse's or licensed practical nurse's scope of practice as defined under Minnesota Statutes, sections 148.171 to 148.285. If after a person's annual reassessment under Minnesota Statutes, section 256B.0911, any requirements of this paragraph or paragraph (c) are no longer met, the commissioner must terminate the budget exception.

(e) The commissioner of human services may seek all federal authority necessary to implement this section.

(f) The commissioner must ensure that the new waiver service menu and individual budgets allow people to live in their own home, family home, or any home and community-based setting of their choice. The commissioner must ensure, within available resources and subject to state and federal regulations and law, that waiver reimagine does not result in unintended service disruptions.

(g) ~~No later than July 1, 2026,~~ The commissioner must:

(1) develop and implement an online support planning and tracking tool to provide information in an accessible format to support informed choice for people using disability waiver services that allows access to the total budget available to a person, the services for which they are eligible, and the services they have chosen and used. This information must be provided to persons currently using disability waiver services at least 12 months prior to the date their services will be subjected to the budget;

(2) explore operability options that facilitate real-time tracking of a person's remaining available budget throughout the service year; and

(3) seek input from people with disabilities about the online support planning and tracking tool prior to the tool's implementation.

(h) The commissioner must establish a phased approach to implementing the two-waiver program structure. The commissioner must consult with the Olmstead Implementation Office prior to seeking federal approval to ensure the phased approach promotes community integration and continuity of care.

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

Sec. 52. Laws 2026, chapter 95, article 4, section 2, is amended to read:

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

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

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

(c) Permissible exceptions to the moratorium include:

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

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

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

(4) new foster care licenses or community residential setting licenses for people receiving customized living or 24-hour customized living services under the brain injury or community access for disability inclusion waiver plans under section 256B.49 and residing in the customized living setting before July 1, 2026, for which a license is required. A customized living service provider subject to this exception may rebut the presumption that a license is required by seeking a reconsideration of the commissioner's determination. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14. The exception is available until June 30, 2027. This exception is available when:

(i) the person's customized living services are provided in a customized living service setting serving four or fewer people under the brain injury or community access for disability inclusion waiver plans under section 256B.49 in a single-family home operational on or before June 30, 2026. For purposes of this clause, "operational" has the meaning given in section 256B.49, subdivision 28;

(ii) the person's case manager provided the person with information about the choice of service, service provider, and location of service, including in the person's home, to help the person make an informed choice; and

(iii) the person's services provided in the licensed foster care or community residential setting are less than or equal to the cost of the person's services delivered in the customized living setting as determined by the lead agency.

Sec. 53. **WAIVER CASE MANAGEMENT ADVISORY WORKING GROUP.**

Subdivision 1. **Establishment; purpose.** The commissioner of human services shall convene a waiver case management advisory working group. The purpose of the working group is to evaluate and make recommendations regarding the quality, workforce sustainability, accountability, and long-term stability of home and community-based waiver case management services provided under Minnesota Statutes, sections 256B.0913, 256B.092, 256B.0922, and 256B.49, and chapter 256S.

Subd. 2. **Membership.** The commissioner shall appoint members representing diverse geographic regions of the state, including metropolitan and greater Minnesota areas, with at least 30 percent of the members living or working outside the seven-county metropolitan area and including:

(1) representatives of the Department of Human Services;

(2) lead agencies, as defined in Minnesota Statutes, section 256B.0911, subdivision 10;

(3) contracted waiver case management providers;

(4) waiver case managers with current direct service responsibilities;

(5) individuals receiving waiver services or their family members or advocates;

(6) representatives of disability advocacy organizations;

(7) representatives of the Minnesota Disability Law Center;

(8) representatives of culturally specific or Tribal communities; and

(9) workforce representatives with experience in human services.

Subd. 3. **Compensation; expenses.** Members of the working group may receive compensation and expense reimbursement as provided in Minnesota Statutes, section 15.059, subdivision 3.

Subd. 4. **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. Meetings are subject to Minnesota Statutes, chapter 13D. 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. 5. **Duties.** The working group shall:

(1) evaluate the impact of current funding levels, workforce capacity, administrative requirements, and caseload expectations on service delivery and quality outcomes;

(2) examine accountability and oversight mechanisms and grievance processes across delivery models;

(3) review available data related to workforce vacancies, turnover, compensation, and service access;

(4) identify barriers to maintaining high-quality and culturally responsive case management services;

(5) examine case management training requirements and core competencies;

(6) evaluate client transfer and service continuity processes; and

(7) develop recommendations, including potential legislative or administrative changes, to ensure a stable, accountable, and high-quality waiver case management system that supports person-centered planning and informed choice.

Subd. 6. **Report.** By September 1, 2027, the commissioner shall submit a report summarizing the working group's findings and 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.

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

Sec. 54. **DIRECTION TO COMMISSIONER; HCBS WAIVER CASE MANAGEMENT EVALUATION AND REPORT.**

(a) The commissioner of human services must evaluate reimbursement rates and lead agency duties associated with home and community-based services (HCBS) case management under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S. The commissioner must develop an updated payment methodology for waiver case management that reasonably covers the cost to provide high-quality, person-centered, and culturally responsive case management services. The report must, at a minimum, include:

(1) an evaluation of costs and workforce pressures that impact the delivery of case management services;

(2) an evaluation of costs to provide culturally responsive case management services;

(3) an evaluation of current reimbursement rates, methodologies, and the extent to which rates cover costs to provide services and attract and retain case managers;

(4) an evaluation of current caseload sizes and recommended best practices for caseload and case mix;

(5) identification and evaluation of the required professional qualifications, experience, and training of case management professionals; and

(6) recommended HCBS waiver rate methodology, specified cost components, weighted values, and modeled rate frameworks.

(b) The commissioner must consult with interested parties, including but not limited to lead agencies, contracted case management services providers, individuals receiving services and their families, advocacy organizations, and relevant experts. The commissioner must

consider the recommendations of the waiver case management advisory working group under section 53 when developing recommendations under this section.

(c) The commissioner may contract with rate experts to develop and model recommended rates.

(d) By December 15, 2028, the commissioner of human services must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services with the findings and recommendations of the evaluation.

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

Sec. 55. **INTEGRATED COMMUNITY SUPPORTS REFORM STUDY.**

Subdivision 1. **Review and evaluation.** (a) The commissioner of human services must review the medical assistance integrated community supports (ICS) service provided under the home and community-based waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, and evaluate the need for statutory, regulatory, and programmatic reforms. At a minimum, the evaluation must include:

(1) an examination of current provider standards, service delivery models, and oversight mechanisms applicable to ICS providers;

(2) an assessment of the effectiveness of ICS in supporting individuals to live independently in community settings, including outcomes related to service utilization and health and safety;

(3) a review of payment methodologies, including rate structures, administrative components, and alignment with federal Medicaid requirements under home and community-based services waivers and state plan authorities;

(4) an environmental scan of comparable supportive housing and community-based service models in other states, including best practices for program integrity, quality assurance, and service coordination;

(5) an assessment of program integrity risks, including billing practices and service verification; and

(6) identification of opportunities to improve coordination between ICS providers and lead agencies.

(b) The commissioner may hire a third-party contractor to perform activities necessary to complete the evaluation. Any contract with a contractor under this section is not subject

to the statewide contracting provisions under Minnesota Statutes, sections 16C.05, subdivisions 1 to 4, and 16C.06.

Subd. 2. **Community consultation.** The commissioner must consult with the community in conducting the review under this section. The community must include, at a minimum:

(1) individuals who receive ICS services and self-advocates;

(2) family members and caregivers of individuals who receive ICS services;

(3) ICS providers;

(4) counties and Tribal Nations serving as lead agencies; and

(5) advocacy organizations representing people with disabilities.

Subd. 3. **Reports.** (a) The commissioner must develop recommendations for legislative and administrative changes to strengthen the ICS program. Recommendations may include but are not limited to:

(1) establishing risk-based provider oversight and program integrity requirements;

(2) clarifying allowable services and service limits consistent with federal Medicaid requirements, including prohibitions on payment for room and board;

(3) improving service verification, documentation, and accountability measures;

(4) enhancing recipient protections, including person-centered planning and grievance processes;

(5) aligning ICS with home and community-based services settings requirements under Code of Federal Regulations, title 42, section 441.301; and

(6) modifications to the ICS rate methodology.

(b) The commissioner must submit an initial report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by March 1, 2027, and a final report by January 1, 2028. The reports must include findings, community feedback, and specific legislative proposals related to ICS reform.

Sec. 56. **MARKET RATE STUDY FOR HOME AND COMMUNITY-BASED SERVICES.**

(a) The commissioner of human services must conduct a market rate study to evaluate the adequacy, sustainability, and equity of payment rates for specific home and

community-based services under the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49.

(b) The study must include, at minimum, an analysis of the following services:

(1) employment support services delivered in remote or virtual settings;

(2) 24-hour emergency assistance;

(3) assistive technology;

(4) environmental accessibility adaptations;

(5) chore services;

(6) transitional services;

(7) independent living skills training; and

(8) specialist services, including positive support services and orientation and mobility services.

(c) In planning and conducting the market rate study, the commissioner must consult with interested parties, including but not limited to service providers, people with disabilities, lead agencies, Tribal Nations, culturally specific and community-based providers, and disability advocacy organizations. The consultation process must be designed to ensure meaningful participation from providers in greater Minnesota and from providers serving communities of color and Tribal Nations.

(d) In conducting the study, the commissioner must analyze provider costs, workforce availability, wage competitiveness, regional market conditions, inflationary impacts, and access issues. The commissioner must also evaluate whether current reimbursement methodologies reflect actual costs of providing services and support long-term access to qualified providers.

(e) By February 15, 2027, the commissioner must submit a report with findings and recommendations, including but not limited to any proposed statutory changes, to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

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

Sec. 57. **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.

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. 58. **DIRECTION TO COMMISSIONER; ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS FOR HOMES.**

By October 1, 2026, the commissioner of human services must submit to the Centers for Medicare and Medicaid Services waiver plan amendments for the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities 1915(c) waivers to implement the following reforms to environmental accessibility adaptations for homes:

(1) separate the treatment of home modifications from the treatment of vehicle modifications;

(2) replace the existing $40,000 annual limit for home modifications with a $40,000 three-year limit;

(3) replace the existing provisions that permit a two-year limit of $80,000 to be authorized during a two-year period with provisions permitting a six-year limit of $80,000 to be authorized in a five-year period;

(4) limit permissible authorizations for home modifications to only modifications meeting an assessed need that cannot be met in a less costly way in the person's current home;

(5) limit the number of similar or duplicative home modifications to modifications that are necessary for the health and safety of the person; and

(6) establish caps on the number, size, and cost of common home modifications.

Sec. 59. **DIRECTION TO COMMISSIONER; ENVIRONMENTAL ACCESSIBILITY ADAPTATIONS FOR VEHICLES.**

(a) By October 1, 2026, the commissioner of human services must submit to the Centers for Medicare and Medicaid Services waiver plan amendments for the brain injury, community access for disability inclusion, community alternative care, and developmental disabilities 1915(c) waivers to implement the following reforms to environmental accessibility adaptations for vehicles:

(1) separate the treatment of vehicle modifications from the treatment of home modifications;

(2) replace the existing $40,000 annual limit for vehicle modifications with a $40,000 five-year limit; and

(3) permit multiple authorizations for vehicle modifications in a five-year period when a vehicle is sold, provided that subsequent authorizations are limited to:

(i) for a purchased adapted vehicle, the portion of the original purchase cost attributable to the vehicle modifications minus the book value of the purchase price attributable to the vehicle modifications; or

(ii) for vehicle modifications, the original purchase and installation cost of the modifications minus the book value of the modifications.

(b) For purposes of this section, "book value" means the original cost minus the product of 20 percent of the original cost multiplied by the number of years during which the adapted vehicle was used by the person.

Sec. 60. **DIRECTION TO COMMISSIONER; HOME AND COMMUNITY-BASED SERVICES ACCESS RULE IMPLEMENTATION.**

The commissioner of human services must develop systems and capacity to comply with the requirements of the federal access rule to improve access to care, quality and health outcomes, and program integrity in medical assistance home and community-based services. The initial phase of implementation efforts for home and community-based services must include:

(1) updating critical incident oversight by implementing a system to track trends, resolution of incidents, and other information to enhance protections and improve outcomes for recipients;

(2) establishing a home and community-based services grievance procedure and work unit to accept, investigate, and resolve grievances for home and community-based service recipients related to service providers, lead agencies, and the department;

(3) establishing an advisory body for interested parties to advise on services, including direct care workers, beneficiaries, authorized representatives, and other individuals impacted by service rates;

(4) establishing an advisory body for current and former beneficiaries, family members, and caregivers to advise the commissioner on policy and program administration;

(5) publishing all medical assistance fee-for-service fee schedule payment rates; and

(6) developing and reporting on home and community-based service program integrity and quality measures to demonstrate state outcomes on wait list times; access to certain services, including the average time from eligibility determination to service commencement; service utilization; and other quality metrics.

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

Sec. 61. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall renumber the definitions in Minnesota Statutes, section 256B.85, subdivision 2, and the definitions in Minnesota Statutes, section 256B.851, subdivision 2, as subdivisions in Minnesota Statutes, section 256B.8502, rearranging the renumbered and existing definitions in Minnesota Statutes, section 256B.8502, as necessary to place them in alphabetical order. The revisor of statutes shall revise all statutory cross-references consistent with this recoding.

(b) If a provision of Minnesota Statutes, section 256B.85, subdivision 2, or 256B.851, subdivision 2, is amended or repealed in the 2026 regular legislative session, the revisor of statutes shall codify the amendment or repealer in Minnesota Statutes, section 256B.8502, notwithstanding any other law to the contrary.

Sec. 62. **REPEALER.**

(a) Minnesota Statutes 2024, section 256B.0911, subdivision 21, is repealed.

(b) Minnesota Statutes 2025 Supplement, section 256B.0911, subdivisions 24a and 25a, are repealed.

(c) Minnesota Statutes 2024, section 256B.0921, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective January 1, 2027. Paragraph (b) is effective the day following final enactment.

ARTICLE 10
ELECTRONIC VISIT VERIFICATION

Section 1. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(c) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transportation, within the meaning of "public transportation" as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472, subdivision 1, paragraph (p).

(d) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph. This paragraph expires upon the effective date of paragraph (e).

(e) Effective January 1, 2027, or upon federal approval, whichever is later, medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers must bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria and comply with the requirements under section 256B.073. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements in this paragraph.

~~(e)~~ (f) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

~~(f)~~ (g) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(g)~~ (h) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid medical assistance, the administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care program beneficiaries to obtain covered medical services; and

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode.

~~(h)~~ (i) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph ~~(n)~~ (o), clauses (4), (5), (6), and (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(i)~~ (j) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

~~(j)~~ (k) Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary

care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(k)~~ (l) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, nonemergency medical transportation providers must take clients to the health care provider using the most direct route and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the administrator.

~~(l)~~ (m) Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

~~(m)~~ (n) The administrative agency shall use the level of service process established by the commissioner to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

~~(n)~~ (o) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

~~(o)~~ (p) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph ~~(n)~~ (o) according to paragraphs ~~(r)~~ (s) to ~~(t)~~ (u) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(p)~~ (q) The commissioner shall:

(1) verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

~~(q)~~ (r) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(r)~~ (s) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $12.10 for the base rate and $1.43 per mile when provided by a nonemergency medical transportation provider;

(4) $14.30 for the base rate and $1.43 per mile for assisted transport;

(5) $19.80 for the base rate and $1.70 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(s)~~ (t) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle used to provide the service.

~~(t)~~ (u) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph ~~(r)~~ (s), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph ~~(r)~~ (s), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph ~~(r)~~ (s), clauses (1) to (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(u)~~ (v) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs ~~(r)~~ (s) to ~~(t)~~ (u), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(v)~~ (w) The commissioner, when determining reimbursement rates for nonemergency medical transportation, shall exempt all modes of transportation listed under paragraph ~~(n)~~ (o) from Minnesota Rules, part 9505.0445, item R, subitem (2).

~~(w)~~ (x) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00

per gallon, the commissioner shall adjust the rate paid per mile in paragraph ~~(r)~~ (s) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 17b, is amended to read:

Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency medical transportation providers must document each occurrence of a service provided to a recipient according to this subdivision. Providers must maintain records sufficient to distinguish individual trips with specific vehicles and drivers. The documentation may be collected and maintained using electronic systems or software or in paper form but must be made available and produced upon request. Program funds paid for transportation that is not documented according to this subdivision may be subject to recovery by the commissioner pursuant to section 256B.064.

(b) A nonemergency medical transportation provider must compile transportation trip records that are written in English and legible according to the standard of a reasonable person and that include each of the following elements:

(1) the recipient's name;

(2) the date or dates the service is provided, if different than the date the entry was made;

(3) either the printed name of the driver sufficient to distinguish the driver of service or the driver's provider number;

(4) the date and the signature of the driver attesting that the record accurately represents the services provided and the actual miles driven, and acknowledging that misreporting information that results in ineligible or excessive payments may result in civil or criminal action;

(5) the date and the signature of the recipient or authorized party attesting that transportation services were provided as indicated on the transportation trip record, or the signature of the medical services provider certifying that the recipient was transported to the medical services provider destination. In the event that both the medical services provider and the recipient or authorized party refuse or are unable to provide signatures, the driver

must document on the transportation trip record that signatures were requested and not provided;

(6) the address, or the description if the address is not available, of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

(7) the name or number of the mode of transportation in which the service is provided;

(8) the license plate number of the vehicle used to transport the recipient;

(9) the time of the recipient pickup;

(10) the time of the recipient drop-off;

(11) the odometer reading of the vehicle used to transport the recipient taken at the time of pickup;

(12) the odometer reading of the vehicle used to transport the recipient taken at the time of drop-off;

(13) the name of the extra attendant when an extra attendant is used to provide special transportation service; and

(14) the documentation indicating the method that was used to determine the most direct route.

(c) In determining whether the commissioner will seek recovery, the documentation requirements in this section apply retroactively to audit findings beginning January 1, 2020, and to all audit findings thereafter.

(d) Effective January 1, 2027, or upon federal approval, whichever is later, records that comply with section 256B.073 may be used to meet the requirements under this subdivision if all required elements are included in the record.

Sec. 3. Minnesota Statutes 2024, section 256B.073, subdivision 1, is amended to read:

Subdivision 1. **Documentation; establishment and operation.** The commissioner of human services shall establish ~~implementation requirements and standards for~~ and maintain the requirements and standards for the ongoing operation of electronic visit verification to comply with the 21st Century Cures Act, Public Law 114-255. Within available appropriations, the commissioner shall take steps to comply with the electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

Sec. 4. Minnesota Statutes 2024, section 256B.073, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have the meanings given ~~them~~.

(b) "Data aggregator" means the entity designated by the commissioner to collect, store, and transmit electronic visit verification data from providers and third-party systems to the commissioner in accordance with the standards and requirements established under this section.

~~(b)~~ (c) "Electronic visit verification" or "EVV" means the ~~electronic documentation of~~ ~~the~~ process required under this section and United States Code, title 42, section 1396b(l), used to electronically verify the:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

(d) "Electronic visit verification data" means information collected through an electronic visit verification system, including data elements required under United States Code, title 42, section 1396b(l), and any additional data elements specified by the commissioner under this section.

~~(c)~~ (e) "Electronic visit verification system" means a system ~~that provides electronic verification of services~~ used to collect, verify, and transmit electronic visit verification data to the commissioner or the commissioner's designated data aggregator that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

(f) "Electronic visit verification vendor" means any entity that develops, provides, or supports an electronic visit verification system, including the state-provided vendor and any third-party vendor.

(g) "Financial management services provider" means an entity enrolled with the commissioner to provide financial management services under section 256B.85 or other applicable law and responsible for fiscal, payroll, and reporting functions on behalf of participant employers.

(h) "Home health agency" means a home care provider agency that is Medicare certified under Code of Federal Regulations, title 42, part 484, and licensed as a home care provider under chapter 144A.

(i) "Individual" means a person who receives services subject to electronic visit verification under the medical assistance program.

(j) "Managed care organization" means a public or private organization that contracts with the commissioner under section 256B.69 or other applicable law to deliver health care services to individuals eligible for medical assistance or MinnesotaCare.

(k) "Manual visit" means a visit:

(1) entered administratively and not by the caregiver at the time of service delivery; or

(2) where data elements are edited after the time of service delivery.

(l) "Provider" means an individual or organization that meets one or more of the following conditions:

(1) is enrolled as a Minnesota health care programs provider;

(2) provides services through a managed care organization under contract with the commissioner under section 256B.69;

(3) is a financial management services provider; or

(4) is a participant employer under section 256B.85, subdivision 7, or an employer of record that is directing services under section 256B.49, subdivision 16.

~~(d)~~ (m) "Service" means one of the following:

(1) personal care assistance services as defined in section 256B.0625, subdivision 19a, and provided according to section 256B.0659;

(2) community first services and supports under section 256B.85;

(3) home health services under section 256B.0625, subdivision 6a; ~~or~~

(4) adult companion services;

(5) adult day services;

(6) adult rehabilitative mental health services;

(7) assertive community treatment;

(8) early intensive developmental and behavioral intervention;

(9) integrated community supports;

(10) nonemergency medical transportation services;

(11) recovery peer support;

(12) home and community-based services reimbursed at an hourly or specified minute-based rate and provided according to a federally approved waiver plan as authorized under chapter 256S or section 256B.0913, 256B.092, or 256B.49; or

(13) other medical supplies and equipment or home and community-based services that are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

(n) "State-provided electronic visit verification system" means the electronic visit verification system made available by the commissioner to providers at no cost for services subject to federal electronic visit verification requirements.

(o) "Third-party electronic visit verification system" means an electronic visit verification system purchased or operated by a provider or vendor other than the state-provided system designated by the commissioner.

(p) "Verification method" means the electronic process used to capture and verify visit information, including telephone, fixed visit verification devices, or mobile applications, as approved by the commissioner.

(q) "Visit" means a single occurrence of service delivery subject to electronic visit verification.

(r) "Worker" means an individual who provides personal care assistance services, community first services and supports, home health services, consumer-directed community supports, or other services identified by the commissioner as subject to electronic visit.

Sec. 5. Minnesota Statutes 2024, section 256B.073, subdivision 3, is amended to read:

Subd. 3. **Requirements.** (a) In ~~developing implementation requirements for~~ administering electronic visit verification, the commissioner ~~shall~~ must ensure that the system and related requirements:

(1) are ~~minimally~~ administratively and financially ~~burdensome to a provider~~ reasonable for providers of services;

(2) ~~are minimally burdensome~~ support continued access to ~~the~~ services and are designed to avoid disruption to service ~~recipient and the least disruptive to the service recipient in receiving and maintaining allowed services~~ delivery or receipt;

(3) consider existing best practices and use of electronic visit verification;

(4) are conducted according to all state and federal laws;

(5) are effective methods for preventing fraud when balanced against the requirements of clauses (1) and (2); and

(6) are consistent with the Department of Human Services' policies related to covered services, flexibility of service use, and quality assurance.

(b) The commissioner ~~shall~~ must make training and guidance available to providers of services on the electronic visit verification ~~system~~ requirements and system use.

(c) The commissioner ~~shall~~ must establish baseline measurements related to preventing fraud and establish measures to determine the effect of electronic visit verification requirements on program integrity.

(d) The commissioner ~~shall~~ must make a ~~state-selected~~ state-provided electronic visit verification system available to providers of services.

(e) The commissioner ~~shall~~ must make available and publish on the agency website the name and contact information for the vendor of the ~~state-selected~~ state-provided electronic visit verification system and the other vendors that offer alternative electronic visit verification systems. The information provided must state that the ~~state-selected~~ state-provided electronic visit verification system is offered at no cost to the provider of services and that the provider of services may choose an alternative system that may be at a cost to the provider.

(f) The commissioner may establish implementation dates and implementation schedules for system functions subject to electronic visit verification under this section, including but not limited to verification methods or technical requirements.

(g) The commissioner may waive the requirements under this section for any service component or setting when the application of electronic visit verification is contrary to paragraph (a).

Sec. 6. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 4a. **Electronic visit verification system options.** (a) A provider of services must use an electronic visit verification system that complies with the requirements established by the commissioner. A provider of services may use either the state-provided system or a

third-party system. All systems used for compliance must provide data to the commissioner in the format and with the frequency required by the commissioner.

(b) The commissioner must make a state-provided electronic visit verification system available at no cost to providers of services. The commissioner must provide training on the system to all providers of services.

(c) The commissioner must allow providers of services to utilize a third-party electronic visit verification system that the commissioner determines meets the requirements under this section.

(d) A provider of services using a third-party electronic visit verification system that meets all technical specifications and federal and state laws must:

(1) collect and submit all data for each visit to the commissioner, including but not limited to manual entries;

(2) maintain compliance identified by the commissioner, including but not limited to incorporating into the system any changes in data requirements that must be transmitted to the commissioner; and

(3) integrate the system with the data aggregator to accurately send data.

(e) The data aggregator must be available at no cost to a provider of services for purposes of transmitting electronic visit verification data from approved third-party systems to the commissioner. Any costs associated with the development and use of a third-party system are the responsibility of the provider.

(f) If a provider is unable to integrate a third-party system with the data aggregator, the provider of services must use the state-provided electronic visit verification system.

(g) The commissioner must provide training on reviewing and correcting imported data in the data aggregator to providers of services.

Sec. 7. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 4b. **Provider responsibilities.** A provider of services must:

(1) use an electronic visit verification system that meets all technical and data submission requirements established by the commissioner;

(2) enroll with the state-provided electronic visit verification system or the data aggregator, as applicable;

(3) provide all information requested by the commissioner for enrollment, access, and data submission and ensure that the information remains accurate and up to date;

(4) maintain records for each individual receiving services subject to electronic visit verification, including but not limited to all required data elements;

(5) maintain a current list of workers providing services subject to electronic visit verification to individuals receiving services under medical assistance;

(6) provide the commissioner and any managed care organization with immediate, direct, and on-site or remote access to the electronic visit verification system;

(7) at the request of the commissioner or a managed care organization, allow review or copying of electronic visit verification documentation at no cost;

(8) ensure that electronic visit verification systems and related processes meet accessibility and confidentiality requirements under state and federal law;

(9) comply with all policies, procedures, and technical specifications issued by the commissioner under this section; and

(10) ensure that workers, participants, and other individuals using electronic visit verification are trained and comply with all documentation and data entry requirements established by the commissioner.

Sec. 8. Minnesota Statutes 2024, section 256B.073, subdivision 5, is amended to read:

Subd. 5. **Vendor requirements.** (a) The vendor of the electronic visit verification system ~~selected~~ provided by the commissioner and the vendor's affiliate must comply with the requirements of this subdivision.

(b) The vendor of the ~~state-selected~~ state-provided electronic visit verification system and the vendor's affiliate must:

(1) notify the provider of services that the provider may choose the ~~state-selected~~ state-provided electronic visit verification system at no cost to the provider;

(2) offer the ~~state-selected~~ state-provided electronic visit verification system to the provider of services prior to offering any fee-based electronic visit verification system;

(3) notify the provider of services that the provider may choose any fee-based electronic visit verification system prior to offering the vendor's or its affiliate's fee-based electronic visit verification system; and

(4) when offering the ~~state-selected~~ state-provided electronic visit verification system, clearly differentiate between the ~~state-selected~~ state-provided electronic visit verification system and the vendor's or its affiliate's alternative fee-based system.

(c) The vendor of the ~~state-selected~~ state-provided electronic visit verification system and the vendor's affiliate must not use state data that are not available to other vendors of electronic visit verification systems to promote or sell the vendor's or its affiliate's alternative electronic visit verification system.

(d) Upon request from the provider, the vendor of the ~~state-selected~~ state-provided electronic visit verification system must provide proof of compliance with the requirements of paragraph (b).

(e) An agreement between the vendor of the ~~state-selected~~ state-provided electronic visit verification system or its affiliate and a provider of services for an electronic visit verification system that is not the ~~state-selected~~ state-provided system entered into on or after July 1, 2023, is subject to immediate termination by the provider if the vendor violates any of the requirements of paragraph (b).

Sec. 9. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 6. **Data and documentation.** (a) A provider of services must submit electronic visit verification data to the commissioner or the data aggregator in accordance with the technical standards, format, and frequency established under this section. The commissioner may use integrated electronic visit verification data for oversight, quality assurance, and program integrity purposes consistent with state and federal law.

(b) The commissioner and managed care organizations must use electronic visit verification data to validate claims for payment under medical assistance. Claims that cannot be validated in accordance with electronic visit verification requirements may be subject to actions by the commissioner as authorized under state and federal law, including actions related to payment, program integrity, or provider compliance.

(c) A provider of services must record all required electronic visit verification data at the time of service delivery using an approved verification method. To be compliant with electronic visit verification requirements, a provider of services must document a visit with all required data elements recorded at the time of service delivery.

(d) A manual visit does not comply with electronic visit verification requirements. A manual visit must be confirmed and verified according to processes established by the commissioner before being used to validate or support a claim for payment.

(e) A worker providing services subject to electronic visit verification must record the start and end times of each visit at the time the service is delivered using an approved verification method. A worker must complete and verify all time documentation, including but not limited to verification of service type, date, and duration, on the date the service occurs and be consistent with documentation requirements of the service being provided. A provider of services must maintain documentation demonstrating compliance with this subdivision and make the documentation available to the commissioner or a managed care organization upon request.

Sec. 10. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 7. **Third-party system responsibilities.** (a) This subdivision is effective for Early Intensive Developmental and Behavioral Intervention services beginning July 1, 2027, or upon federal approval, whichever is later. This subdivision is effective for all other services subject to this subdivision beginning January 1, 2027, or upon federal approval, whichever is later.

(b) A provider of services using a third-party electronic visit verification system must ensure that the system meets all technical, functional, and data-exchange requirements established by the commissioner and transmits data to the commissioner or the data aggregator in the format and with the frequency required by the commissioner.

(c) A third-party electronic visit verification vendor must:

(1) comply with all technical, contractual, privacy, and security standards established by the commissioner;

(2) not use or disclose state data for any purpose other than fulfilling the requirements under this section or federal law;

(3) provide the commissioner access to system documentation, data mapping, and audit records upon request; and

(4) immediately report to the commissioner any data transmission failure, breach, or interruption affecting the commissioner's ability to receive required electronic visit verification data.

(d) A provider of services remains responsible for ensuring compliance with this section even when using a third-party electronic visit verification system.

(e) The third-party vendor must ensure training on the system is available to providers of services.

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

Sec. 11. **ELECTRONIC VISIT VERIFICATION AND MEDICAL ASSISTANCE CLAIMS VALIDATION.**

(a) The commissioner of human services must develop, test, and implement systems changes necessary to integrate data collected through electronic visit verification systems, as described under Minnesota Statutes, section 256B.073, with Minnesota's Medicaid Management Information System. Data collected through electronic visit verification systems must be used as part of the commissioner's processes for validating claims for services subject to electronic visit verification.

(b) The commissioner of human services must require that managed care plans and county-based purchasing plans ensure electronic visit verification and claims system interoperability by January 1, 2027.

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

Sec. 12. **REPEALER.**

Minnesota Statutes 2024, section 256B.073, subdivision 4, is repealed.

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

ARTICLE 11
MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 142E.16, is amended by adding a subdivision to read:

Subd. 1a. **Training required for payments.** (a) As a condition of payment and prior to authorization, all providers receiving child care assistance payments must complete compliance training developed by the commissioner that addresses program integrity requirements including but not limited to record keeping and billing requirements. The commissioner shall develop criteria, reporting requirements, and standards for when providers need to renew training after their initial registration.

(b) Providers that do not have an active registration to receive child care assistance on or before April 10, 2028, must complete the training under this subdivision prior to authorization. Providers with an active registration on or before April 10, 2028, must complete the training under this subdivision before the provider's first renewal after April 10, 2028, or April 9, 2029, whichever is later.

Sec. 2. Minnesota Statutes 2024, section 245.096, is amended to read:

245.096 CHANGES TO GRANT PROGRAMS.

Prior to implementing any ~~substantial~~ changes to a grant funding formula disbursed through allocations administered by the commissioner, the commissioner must provide a report on the nature of the changes, the effect the changes will have, whether any funding will change, and other relevant information, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services. The report must be provided prior to the start of a regular session, and the proposed changes cannot be implemented until after the adjournment of that regular session.

Sec. 3. **DIRECTION TO COMMISSIONER; ASSESSMENT OF ADMINISTRATIVE ROLES.**

(a) The commissioners of human services and children, youth, and families, in consultation with Minnesota's Tribal Nations and counties, must conduct a study to assess and recommend improvements to the roles and responsibilities of the Departments of Human Services and Children, Youth, and Families, the counties, and Minnesota's Tribal Nations in administering human services programs.

(b) The study must include a comprehensive review of programs administered by the departments, 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, economic assistance, child support, child care and early learning, and licensing and oversight functions.

(c) The study must evaluate the:

(1) current roles and responsibilities held by the departments, the counties, and Minnesota's 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 departments, the counties, and Minnesota's Tribal Nations;

(4) variations in service delivery between different geographical regions of the state; and

(5) 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 departments, the counties, and Minnesota's 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) Notwithstanding Minnesota Statutes, chapter 13, or other statutes or rules to the contrary, counties must provide financial, human resources, and other information necessary to complete the study in the form and manner and on the timeline requested by the commissioners.

(g) By October 1, 2028, the commissioners must submit a report on the study and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health; human services; and children, youth, and families policy and finance.

Sec. 4. **DIRECTION TO COMMISSIONER; TRANSFER ASSESSMENT.**

(a) The commissioner of human services must procure a contract with a vendor to assess the current status of administration of medical assistance and plan for a transfer of administration of medical assistance to the commissioner by January 1, 2033. The commissioner must submit the assessment and plan 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 and plan 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 Minnesota's 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. 5. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; EVALUATION OF DHS STRUCTURE AND PROCESSES.**

(a) The commissioner of human services must contract with an external consultant to continue and complete the project initiated under Executive Order 25-10, section 1, paragraph (g), to make recommendations to improve the Department of Human Services' performance as the state's Medicaid agency. The external consultant must evaluate the department's structure and processes and assess the adequacy of the department's current policies, procedures, systems, organizational structure, staffing levels, and funding to effectively increase program integrity, minimize fraud, and more effectively serve as the state's Medicaid agency.

(b) Within 60 days of receiving the external consultant's recommendations, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, including information on the recommendations of the external consultant and any actions the commissioner has taken in response to the external consultant's recommendations or

other actions taken by the commissioner pursuant to Executive Order 25-10, section 1, paragraph (g).

(c) Within 60 days of receiving the external consultant's recommendations, the commissioner must submit a summary of the recommendations of the external consultant with whom the commissioner contracted under Executive Order 25-10, section 1, paragraph (g), and any actions the commissioner has taken in response to either the external consultant's recommendations or other actions taken by the commissioner pursuant to Executive Order 25-10, section 1, paragraph (g). The summary must be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

(d) Within 60 days of receiving the external consultant's recommendations, the commissioner must submit the external consultant's report summarizing the evaluation and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. The commissioner must also submit draft legislative language to implement the recommendations of the external consultant's recommendations.

Sec. 6. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; CODIFYING THE OFFICE OF INSPECTOR GENERAL.**

(a) By December 1, 2026, the commissioner of human services must provide statutory language that codifies the Department of Human Services Office of Inspector General to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and the nonpartisan staff from House Research Department and Senate Counsel, Research, and Fiscal Analysis whose drafting areas include human services. The statutory language must only contain:

(1) existing legal authority identified by the office that the office relies upon to carry out its duties; and

(2) policies and procedures necessary for the office to carry out its existing duties.

(b) The commissioner must not include desired policy changes to the office, its structure, or its duties within the codification language required under paragraph (a).

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

ARTICLE 12

DHS APPROPRIATIONS

Section 1. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2025, First Special Session chapter 3, article 20, and Laws 2025, First Special Session chapter 9, article 12, to the agency and for purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the addition to or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2025, First Special Session chapter 3, article 20, and Laws 2025, First Special Session chapter 9, article 12. Appropriations and reductions to appropriations for the fiscal year ending June 30, 2026, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **TOTAL APPROPRIATION**	**$ (10,098,000)**	**$ (50,711,000)**
Sec. 3. **CENTRAL OFFICE; OPERATIONS**	**$ -0-**	**$ 27,743,000**

Subdivision 1. **Evaluation of DHS Structure and Processes**

$500,000 in fiscal year 2027 is for a comprehensive evaluation of the Department of Human Services structure and processes. This is a onetime appropriation and is available until June 30, 2028.

Subd. 2. **Assessment of State, County, and Tribal Nation Roles in Administering Human Services Programs**

$3,000,000 in fiscal year 2027 is for an assessment of state, county, and Tribal Nation roles in administering human services programs. This is a onetime appropriation and is available until June 30, 2029.

Subd. 3. **Prepayment Review Vendor Contract**

$2,500,000 in fiscal year 2027 is to conduct ongoing prepayment claims analysis technology for services provided under medical assistance. This is a onetime appropriation.

Subd. 4. **Prepayment Review Technology Contract**

$4,000,000 in fiscal year 2027 is for a competitively awarded vendor contract to support prepayment review technology to build on and reference existing claims edits infrastructure, prior authorization criteria, and continuous refining of the prepayment review analytic module to automate fraud detection and payment integrity based on findings over time.

Subd. 5. **Base Level Adjustment**

The general fund base is increased by $22,617,000 in fiscal year 2028 and increased by $20,320,000 in fiscal year 2029.

Sec. 4. **CENTRAL OFFICE; HEALTH CARE** **$** **-0-** **$** **4,169,000**

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 Level Adjustment**

The general fund base is increased by $2,627,000 in fiscal year 2028 and increased by $3,782,000 in fiscal year 2029.

Sec. 5. **CENTRAL OFFICE; AGING AND DISABILITY SERVICES** **$ (3,745,000) $ 19,404,000**

Subdivision 1. **Market Rate and Homemaker Services Rate Study**

$500,000 in fiscal year 2027 is for a study on rate setting methodologies for services currently offered under market rate methodologies and homemaker services. This is onetime appropriation and is available until June 30, 2028.

Subd. 2. **MnCHOICES Redesign Working Group**

$450,000 in fiscal year 2027 is for a contract related to the MnCHOICES redesign working group. The base for this appropriation is $500,000 in fiscal year 2028, $250,000 in fiscal year 2029, $0 in fiscal year 2030, and $0 in fiscal year 2031.

Subd. 3. **Waiver Case Management Advisory Working Group**

$350,000 in fiscal year 2027 is for a contract related to the waiver case management advisory working group. The base for this appropriation is $150,000 in fiscal year 2028 and $0 in fiscal year 2029.

Subd. 4. **HCBS Waiver Case Management Evaluation and Report**

$200,000 in fiscal year 2027 is for a rates study for case management and home and community-based services. This is a onetime appropriation and is available until June 30,

2028. The base for this appropriation is $400,000 in fiscal year 2028 and $0 in fiscal year 2029.

Subd. 5. **Nursing Facility Workforce Wage Supplement Program**

$3,000,000 in fiscal year 2027 is for a contract to administer the nursing facility workforce wage supplement program under Minnesota Statutes, section 256R.60. This is a onetime appropriation and is available until June 30, 2028.

Subd. 6. **Integrated Community Supports Reform Study**

$300,000 in fiscal year 2027 is for an integrated community supports reform study. This is a onetime appropriation and is available until June 30, 2028.

Subd. 7. **Base Level Adjustment**

The general fund base is increased by $24,811,000 in fiscal year 2028 and increased by $32,767,000 in fiscal year 2029.

Sec. 6. **CENTRAL OFFICE; BEHAVIORAL HEALTH** **$** **-0-** **$** **2,382,000**

Subdivision 1. **Access to Services for Incarcerated Individuals Evaluation**

$150,000 in fiscal year 2027 is for community engagement and evaluation related reentry services.

Subd. 2. **Base Level Adjustment**

The general fund base is increased by $2,974,000 in fiscal year 2028 and increased by $2,957,000 in fiscal year 2029.

Sec. 7. **CENTRAL OFFICE; OFFICE OF INSPECTOR GENERAL** **$** **-0-** **$** **16,328,000**

Subdivision 1. **Postpayment Review of Managed Care Organization Billing**

The base must include $30,000,000 in fiscal year 2028 and $30,000,000 in fiscal year 2029 for a competitively awarded vendor contract to support postpayment review of managed care organization billing.

Subd. 2. **Base Level Adjustment**

The general fund base is increased by $49,482,000 in fiscal year 2028 and increased by $49,333,000 in fiscal year 2029. The special revenue government fund base is increased by $1,426,000 in fiscal year 2028 and increased by $2,352,000 in fiscal year 2029.

Sec. 8. **FORECASTED PROGRAMS; HOUSING SUPPORT**	**$**	**-0-**	**$**	**12,524,000**
Sec. 9. **FORECASTED PROGRAMS; MEDICAL ASSISTANCE**	**$**	**-0-**	**$**	**(122,888,000)**
Sec. 10. **FORECASTED PROGRAMS; ALTERNATIVE CARE**	**$**	**-0-**	**$**	**(213,000)**
Sec. 11. **FORECASTED PROGRAMS; BEHAVIORAL HEALTH FUND**	**$**	**-0-**	**$**	**(19,248,000)**
Sec. 12. **GRANT PROGRAM; OTHER LONG-TERM CARE GRANTS**	**$**	**(972,000)**	**$**	**7,683,000**

Subdivision 1. **Nursing Facility Workforce Wage Supplement Program**

$9,508,000 in fiscal year 2027 is for the nursing facility workforce wage supplement program under Minnesota Statutes, section 256R.60. This is a onetime appropriation and is available until June 30, 2028.

Subd. 2. **Linguistically and Culturally Specific Training**

$250,000 in fiscal year 2027 is for a grant to Isuroon to support its mission to provide: (1) linguistically and culturally specific services and in-person training to bilingual individuals, particularly bilingual women from diverse ethnic backgrounds, to navigate health care systems, to advocate for their well-being when accessing health care, to develop financial literacy, to increase civic engagement, and to develop leadership skills; and (2) technical assistance to health care providers through training, resources, and ongoing support. The base for this appropriation is $500,000 in fiscal year 2028 and $500,000 in fiscal year 2029.

Subd. 3. **Base Level Adjustment**

The general fund base is decreased by $1,425,000 in fiscal year 2028 and decreased by $1,425,000 in fiscal year 2029.

Sec. 13. **GRANT PROGRAM; AGING AND ADULT SERVICES GRANTS** **$ (477,000)** **$ -0-**

Sec. 14. **GRANT PROGRAM; DISABILITIES GRANTS** **$ (2,256,000)** **$ (145,000)**

Base Level Adjustment. The general fund base is decreased by $956,000 in fiscal year 2028 and decreased by $956,000 in fiscal year 2029.

Sec. 15. **GRANT PROGRAMS; HOUSING GRANTS** **$ (1,112,000)** **$ 1,250,000**

Subdivision 1. **Housing Support Capacity-Building Grants**

$1,250,000 in fiscal year 2027 is for housing support capacity-building grants. This is a

onetime appropriation and is available until June 30, 2028.

Subd. 2. **Base Level Adjustment**

The general fund base for this appropriation is $0 in fiscal year 2028 and $0 in fiscal year 2029.

Sec. 16. **GRANT PROGRAMS; ADULT MENTAL HEALTH GRANTS**	**$**	**(20,000)**	**$**	**-0-**
Sec. 17. **GRANT PROGRAMS; CHILD MENTAL HEALTH GRANTS**	**$**	**(1,516,000)**	**$**	**-0-**
Sec. 18. **GRANT PROGRAMS; SUBSTANCE USE DISORDER GRANTS**	**$**	**-0-**	**$**	**300,000**

Subdivision 1. **Todd County; Peer Recovery Support**

$300,000 in fiscal year 2027 is for a grant to Todd County for a contract with an organization operating in Todd County to provide daily peer recovery support services and special sessions for individuals who are in substance use recovery, are transitioning out of incarceration, or have experienced trauma.

Subd. 2. **Thrive Family Recovery Resources**

$200,000 in fiscal year 2027 is for a grant to Thrive Family Recovery Resources for a pilot program that provides family peer services, education, resource navigation, and general support for families impacted by substance use disorder. By January 20, 2028, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services that evaluates the results of the pilot program and makes recommendations for developing an ongoing grant program to

provide supportive services and education for families impacted by substance use disorder. This is a onetime appropriation.

Sec. 19. Laws 2025, First Special Session chapter 3, article 20, section 19, subdivision 1, is amended to read:

Subdivision 1. ~~**Intensive Residential Treatment Services**~~ **Community Health Unit; Hennepin County**

$563,000 in fiscal year 2026 is for a grant to the city of Brooklyn Park ~~as start-up funding for an intensive residential treatment services and residential crisis stabilization services facility~~ for the city of Brooklyn Park's Community Health Unit, operating out of the Brooklyn Park Police Department. This is a onetime appropriation and is available until June 30, ~~2027~~ 2028.

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

Sec. 20. Laws 2025, First Special Session chapter 3, article 21, section 3, subdivision 2, is amended to read:

Subd. 2. **Substance Use Treatment, Recovery, and Prevention Grants**

$3,000,000 in fiscal year 2026 and $3,000,000 in fiscal year 2027 are from the general fund for substance use treatment, recovery, and prevention grants under Minnesota Statutes, section 342.72. The commissioner may use up to $300,000 of this appropriation for administration.

Sec. 21. **TRANSFERS AND CANCELLATIONS.**

Subdivision 1. **MnCHOICES modification grants.** The fiscal year 2027 general fund base appropriation for MnCHOICES modifications first established under Laws 2023,

chapter 61, article 9, section 2, subdivision 16, is reduced from $125,000 to $0. The general fund base for this purpose is $0 in fiscal year 2028 and $0 in fiscal year 2029.

Subd. 2. **Day training and habilitation facility grants.** The fiscal year 2028 and fiscal year 2029 general fund base for grant allocations to counties for day training and habilitation services for adults with developmental disabilities when provided as a social service under Minnesota Statutes, sections 252.41 to 252.46, are reduced from $811,000 to $0.

Subd. 3. **Innovation grants.** The fiscal year 2027 general fund base appropriation for the innovation grants program under Minnesota Statutes, section 256B.0921, is reduced from $1,925,000 to $0. The general fund base for this purpose is $0 in fiscal year 2028 and $0 in fiscal year 2029.

Subd. 4. **Preadmission screening grant program.** The fiscal year 2027 general fund base appropriation for the preadmission screening grant program under Minnesota Statutes, section 256.975, subdivision 7d, paragraph (b), is reduced from $20,000 to $0. The general fund base for this purpose is $0 in fiscal year 2028 and $0 in fiscal year 2029.

Subd. 5. **2023 Long-term services and supports loan program.** (a) $65,234,000 in fiscal year 2026 from the long-term services and supports loan program under Minnesota Statutes, section 256.4792, subdivision 8a, is transferred from the long-term services and supports loan account in the special revenue fund to the general fund and is canceled.

(b) Any unencumbered and unexpended amount of the long-term services and supports loan program under Minnesota Statutes, section 256.4792, subdivision 8a, estimated to be $5,620,000, is transferred from the long-term services and supports loan account in the special revenue fund to the general fund and is canceled in fiscal year 2028.

Subd. 6. **2024 Long-term services and supports loan program.** Any unencumbered and unexpended amount of the fiscal year 2026 general fund base appropriation for the long-term services and supports loan program first established under Laws 2024, chapter 125, article 8, section 2, subdivision 12, paragraph (e), estimated to be $822,000, is canceled.

Subd. 7. **Long-term services and supports loan program administrative funding.** Any unencumbered and unexpended amount of the fiscal year 2024 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 5, paragraph (g), clause (3), for administration of the long-term services and supports loan program under Minnesota Statutes, section 256.4792, estimated to be $8,433,000, is transferred from the long-term services and supports loan account in the special revenue fund to the general fund and is canceled.

Subd. 8. **Motion analysis advancements clinical study and patient care.** Any unencumbered and unexpended amount of the fiscal year 2024 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 16, paragraph (l), for the motion analysis advancement clinical study and patient care grant, estimated to be $97,000, is canceled.

Subd. 9. **Aging and disability services for immigrant and refugee communities.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125, article 8, section 2, subdivision 14, paragraph (h), for the aging and disability services for immigrant and refugee communities grant, estimated to be $250,000, is canceled.

Subd. 10. **Health awareness hub pilot project.** (a) Any unencumbered and unexpended amount of the fiscal year 2026 appropriation in Laws 2025, First Special Session chapter 9, article 12, section 15, subdivision 1, for the health awareness hub pilot project grant, estimated to be $150,000, is canceled.

(b) Any unencumbered and unexpended amount of the fiscal year 2027 appropriation in Laws 2025, First Special Session chapter 9, article 12, section 15, subdivision 1, for the health awareness hub pilot project grant, estimated to be $150,000, is canceled.

Subd. 11. **Own home services provider capacity-building.** The amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125, article 8, section 2, subdivision 14, paragraph (j), for the own home services provider capacity-building grant, is reduced by $288,000.

Subd. 12. **License transition support for small disability waiver providers.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125, article 8, section 2, subdivision 14, paragraph (i), for the license transition support for small disability waiver providers grant, estimated to be $1,262,000, is canceled.

Subd. 13. **Parent-to-parent programs.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 16, paragraph (n), for the parent-to-parent programs grant, estimated to be $109,000, is canceled.

Subd. 14. **Dakota County disability services workforce shortage pilot project.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125, article 8, section 2, subdivision 14, paragraph (b), for the Dakota County disability services workforce shortage pilot project grant, estimated to be $250,000, is canceled.

Subd. 15. **Disability services person-centered engagement and navigation study.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125, article 8, section 2, subdivision 4, paragraph (b), for the disability services person-centered engagement and navigation study, estimated to be $438,000, is canceled.

Subd. 16. **Reimbursement for community-first services and supports workers report.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125, article 8, section 2, subdivision 4, paragraph (d), for the reimbursement for community-first services and supports workers report, estimated to be $99,000, is canceled.

Subd. 17. **Aging and disability services administration.** The amount of the fiscal year 2024 appropriation in Laws 2023, chapter 61, article 9, section 2, subdivision 5, paragraph (g), clause (1), for general administrative purposes for the aging and disability services administration, is reduced by $1,797,000.

Subd. 18. **Aging and disability services administration carryforward.** The amount of the fiscal year 2025 carryforward authorization in Laws 2024, chapter 125, article 8, section 2, subdivision 4, paragraph (e), for aging and disability services administration, is reduced by $1,411,000. Of this reduced amount, $1,083,000 is from the presumptive eligibility study, $200,000 is from administration of license transition support for small disability waiver providers, and $128,000 is from administration of the Dakota County disability services workforce shortage pilot project.

Subd. 19. **Aging and adult services.** The fiscal year 2026 general fund base appropriation in Laws 2025, First Special Session chapter 9, article 12, section 16, for aging and adult services grants is reduced by $477,000.

Subd. 20. **Youth peer recovery support services pilot project.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125, article 8, section 2, subdivision 16, for the youth peer recovery support services pilot project, estimated to be $250,000, is canceled.

Subd. 21. **Child mental health.** The fiscal year 2026 general fund base appropriation in Laws 2025, First Special Session chapter 3, article 20, section 20, for child mental health grants is reduced by $266,000.

Subd. 22. **Psychiatric residential treatment facility start-up.** Any unencumbered and unexpended amount of the fiscal year 2024 and fiscal year 2025 appropriations in Laws 2023, chapter 70, article 20, section 2, subdivision 30, paragraph (a), for the psychiatric residential treatment facility start-up grant, estimated to be $1,000,000, are canceled.

Subd. 23. **Mental health innovation grant program.** Any unencumbered and unexpended amount of the fiscal year 2025 appropriation in Laws 2024, chapter 125, article 8, section 2, subdivision 15, paragraph (c), for the mental health innovation grant program, estimated to be $20,000, is canceled.

Subd. 24. **Housing and support services.** The amount of the fiscal year 2026 general fund base appropriation in Laws 2025, First Special Session chapter 3, article 20, section 18, for housing and support services grants, is reduced by $1,112,000. Of this reduced amount:

(1) $250,000 is from transition housing program grants;

(2) $160,000 is from emergency services program grants;

(3) $495,000 is from Homeless Youth Act grants;

(4) $140,000 is from safe harbor grants; and

(5) $67,000 is from shelter-linked mental health grants.

Subd. 25. **Recovery community organization.** Any unencumbered and unexpended amount for the recovery community organization grants first established under Laws 2023, chapter 61, article 9, section 2, subdivision 10, paragraph (h), estimated to be $200,000, is canceled.

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

Sec. 22. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, transfer, or cancellation in this article is enacted more than once during the 2026 regular session, the appropriation, transfer, or cancellation must be given effect once.

Sec. 23. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit.

ARTICLE 13

OTHER AGENCY APPROPRIATIONS

Section 1. **OTHER AGENCY APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2025, First Special Session

chapter 9, article 14, to the agencies and for the purposes specified in this article. The appropriations are from the general fund or other named fund and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the addition or subtraction from the appropriation listed under them is available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. Base adjustments mean the addition to or subtraction from the base level adjustment set in Laws 2025, First Special Session chapter 9, article 14. Supplemental appropriations and reductions to appropriations for the fiscal year ending June 30, 2026, are effective the day following final enactment unless a different effective date is explicit.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **COMMISSIONER OF HEALTH; TOTAL APPROPRIATION**	**$ -0-**	**$ 805,000**
The amounts that may be spent for each purpose are specified in the following sections.		
Sec. 3. **HEALTH PROTECTION**	**$ -0-**	**$ 805,000**
Subdivision 1. **Small Assisted Living Facility Licensure**		
$150,000 in fiscal year 2027 is for the commissioner of health to develop small assisted living facility licensure draft legislation. This is a onetime appropriation and is available until June 30, 2028.		
Subd. 2. **Base Level Adjustment**		
The general fund base is increased by $630,000 in fiscal year 2028 and $630,000 in fiscal year 2029.		
Sec. 4. **COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES**	**$ -0-**	**$ 5,924,000**
Subdivision 1. **Operations and Administration; Agency-Wide Supports**	-0-	5,777,000
(a) **Analysis of Governance Roles for DCYF Programs.** $2,500,000 in fiscal year 2027 is		

for a study to analyze the governance roles for DCYF programs. This is a onetime appropriation and is available until June 30, 2029.

(b) **Base Level Adjustment.** The general fund base is increased by $3,226,000 in fiscal year 2028 and $3,013,000 in fiscal year 2029.

Subd. 2. **Operations and Administration; Early Childhood** -0- 147,000

Base Level Adjustment. The general fund base is increased by $526,000 in fiscal year 2028 and $687,000 in fiscal year 2029.

Subd. 3. **Grant Programs; Support Services Grants** -0- -0-

Fraud Prevention Investigation Grants. The base must include $803,000 in fiscal year 2028 and $803,000 in fiscal year 2029 for additional fraud prevention investigation grants under Minnesota Statutes, section 256.983.

Sec. 5. **COMMISSIONER OF EMPLOYMENT AND ECONOMIC DEVELOPMENT** **$** **-0-** **$** **1,000,000**

$1,000,000 in fiscal year 2027 is for a grant to Turning Point Inc., a 501(c)(3) nonprofit organization, to predesign, design, construct, renovate, furnish, and equip a 32-bed residential facility to be known as "Ms. Bea's" in the metropolitan area, as defined under Minnesota Statutes, section 473.121, subdivision 2. This appropriation includes money for major projects to preserve or replace mechanical, electrical, plumbing, HVAC, and life safety systems; renovation and construction of space for bedrooms, a commercial kitchen, indoor recreation, bathrooms, a workforce development and

resource room, and community common areas; upgrades to achieve compliance with the Americans with Disabilities Act (ADA); and site improvements that prepare the space for future expansion. This appropriation is onetime and is available until the project is completed or abandoned, subject to Minnesota Statutes, section 16A.642.

Sec. 6. **RETURN OF UNUSED TAX-FORFEITED SETTLEMENT APPROPRIATION; CANCELLATION.**

Subdivision 1. **Return of funds.** Notwithstanding the cancellation deadline established in Laws 2024, chapter 113, section 1, subdivision 5, on June 29, 2026, the claims administrator appointed under Laws 2024, chapter 113, to settle litigation related to the state's retention of tax-forfeited lands, surplus proceeds from the sale of tax-forfeited lands, and mineral rights in those lands, must return to the commissioner of management and budget $7,000,000 of the appropriation under Laws 2024, chapter 113, section 1, subdivision 5, that constitutes unspent money in the net settlement fund, as provided in the settlement and final judgment filed on December 16, 2024.

Subd. 2. **Cancellation.** The commissioner of management and budget must cancel the amount received under subdivision 1 to the general fund within one day of the receipt of the money.

Subd. 3. **Application.** The money returned under subdivision 1 are in addition to any other requirements enacted during the 2026 regular legislative session for the claims administrator to return unspent money in the net settlement fund.

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

Sec. 7. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, transfer, or cancellation in this article is enacted more than once during the 2026 regular session, the appropriation, transfer, or cancellation must be given effect once.

Sec. 8. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit.

APPENDIX
Article locations for S4476-4

ARTICLE 1	CONTINUITY OF CARE	Page.Ln 2.36
ARTICLE 2	LONG-TERM CARE FACILITY	Page.Ln 11.18
ARTICLE 3	HEALTH CARE	Page.Ln 19.7
ARTICLE 4	DEPARTMENT OF HUMAN SERVICES OIG POLICY	Page.Ln 96.26
ARTICLE 5	BACKGROUND STUDIES	Page.Ln 150.1
ARTICLE 6	BEHAVIORAL HEALTH	Page.Ln 158.1
ARTICLE 7	UNIFORM SERVICE STANDARDS	Page.Ln 176.14
ARTICLE 8	UNIFORM SERVICE STANDARDS CONFORMING CHANGES	Page.Ln 242.18
ARTICLE 9	AGING AND DISABILITY SERVICES	Page.Ln 255.19
ARTICLE 10	ELECTRONIC VISIT VERIFICATION	Page.Ln 321.6
ARTICLE 11	MISCELLANEOUS	Page.Ln 337.21
ARTICLE 12	DHS APPROPRIATIONS	Page.Ln 342.1
ARTICLE 13	OTHER AGENCY APPROPRIATIONS	Page.Ln 353.26

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.

245A.10 FEES.

Subd. 3a. **Fee for change of ownership exception.** (a) A license holder must submit a fee of $2,100 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(b) License holders under chapter 245D must submit a fee of $4,200 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(c) A license holder for a children's residential facility must submit a fee of $500 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.

Subd. 7. **Children's therapeutic services and supports providers.** The commissioner shall conduct background studies of all direct service providers and volunteers for children's therapeutic services and supports providers under section 256B.0943.

245I.20 MENTAL HEALTH CLINIC.

Subd. 9. **Quality assurance and improvement plan.** (a) At a minimum, a certification holder must develop a written quality assurance and improvement plan that includes a plan for:

(1) encouraging ongoing consultation among members of the treatment team;

(2) obtaining and evaluating feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measuring and evaluating client outcomes;

(4) reviewing client suicide deaths and suicide attempts;

(5) examining the quality of clinical service delivery to clients; and

(6) self-monitoring of compliance with this chapter.

(b) At least annually, the certification holder must review, evaluate, and update the quality assurance and improvement plan. The review must: (1) include documentation of the actions that the certification holder will take as a result of information obtained from monitoring activities in the plan; and (2) establish goals for improved service delivery to clients for the next year.

245I.23 INTENSIVE RESIDENTIAL TREATMENT SERVICES AND RESIDENTIAL CRISIS STABILIZATION.

Subd. 23. **Quality assurance and improvement plan.** (a) A license holder must develop a written quality assurance and improvement plan that includes a plan to:

(1) encourage ongoing consultation between members of the treatment team;

(2) obtain and evaluate feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measure and evaluate client outcomes in the program;

(4) review critical incidents in the program;

(5) examine the quality of clinical services in the program; and

(6) self-monitor the license holder's compliance with this chapter.

(b) At least annually, the license holder must review, evaluate, and update the license holder's quality assurance and improvement plan. The license holder's review must:

(1) document the actions that the license holder will take in response to the information that the license holder obtains from the monitoring activities in the plan; and

(2) establish goals for improving the license holder's services to clients during the next year.

256B.055 ELIGIBILITY CATEGORIES.

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the eligibility requirements in section 256B.056, is not eligible for medical assistance, except for covered services received while an inpatient in a medical institution as defined in Code of Federal Regulations, title 42, section 435.1010. Security issues, including costs, related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

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

(a) "Adult rehabilitative mental health services" means the services described in section 245I.02, subdivision 33.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this section and chapter 245I, as required in section 245I.011, subdivision 5. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) State-level recertification must occur at least every three years.

(d) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(e) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train qualified staff;

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

(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.0701 RECUPERATIVE CARE SERVICES.

Subd. 11. **Requirements for provider enrollment; compliance training.** (a) Effective January 1, 2027, to enroll as a recuperative care provider, a provider must require all owners of the provider who are active in the day-to-day management and operations of the agency and all managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

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

(2) enrollment requirements;

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

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the provider and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the provider. If an individual moves to another recuperative care provider and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) Any recuperative care provider enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

256B.073 ELECTRONIC VISIT VERIFICATION.

Subd. 4. **Provider requirements.** (a) A provider of services may select any electronic visit verification system that meets the requirements established by the commissioner.

(b) All electronic visit verification systems used by providers to comply with the requirements established by the commissioner must provide data to the commissioner in a format and at a frequency to be established by the commissioner.

(c) Providers must implement the electronic visit verification systems required under this section by a date established by the commissioner to be set after the state-selected electronic visit verification systems for personal care services and home health services are in production. For purposes of this paragraph, "personal care services" and "home health services" have the meanings given in United States Code, title 42, section 1396b(l)(5). Reimbursement rates for providers must not be reduced as a result of federal action to reduce the federal medical assistance percentage under the 21st Century Cures Act, Public Law 114-255.

256B.0911 LONG-TERM CARE CONSULTATION SERVICES.

Subd. 21. **MnCHOICES assessments; exceptions following institutional stay.** (a) A person receiving home and community-based waiver services under section 256B.0913, 256B.092, or 256B.49 or chapter 256S may return to a community with home and community-based waiver services under the same waiver without being assessed or reassessed under this section if the person temporarily entered one of the following for 121 or fewer days:

(1) a hospital;

(2) an institution of mental disease;

(3) a nursing facility;

(4) an intensive residential treatment services program;

(5) a transitional care unit; or

(6) an inpatient substance use disorder treatment setting.

(b) Nothing in paragraph (a) changes annual long-term care consultation reassessment requirements, payment for institutional or treatment services, medical assistance financial eligibility, or any other law.

Subd. 24a. **Verbal attestation or alternative to replace required reassessment signatures.** (a) Effective January 1, 2026, or upon federal approval, whichever is later, the commissioner shall allow for verbal attestation or another alternative to replace required reassessment signatures for service initiation.

(b) Within 30 days of completion of a reassessment, an assessor must send a request for written attestation via mail to obtain a signature from the service recipient.

Subd. 25a. **Attesting to no changes in needs or services.** (a) A person who is older than 21 years of age, under 65 years of age, and receiving home and community-based waiver services under the developmental disabilities waiver program under section 256B.092; community access for disability inclusion, community alternative care, and brain injury waiver programs under section 256B.49; or community first services and supports under section 256B.85 may attest that the person has unchanged needs from the most recent prior assessment or reassessment for up to two consecutive reassessments if the lead agency provides informed choice and the person being reassessed or the person's legal representative provides informed consent. Lead agencies must document that informed choice was offered.

(b) The person or person's legal representative must attest, verbally or through alternative communications, that the information provided in the previous assessment or reassessment is still accurate and applicable and that no changes in the person's circumstances have occurred that would require changes from the most recent prior assessment or reassessment. The person or the person's legal representative may request a full reassessment at any time.

(c) The assessor must review the most recent prior assessment or reassessment as required in subdivision 22, paragraphs (a) and (b), clause (1), before conducting the interview. The certified assessor must confirm that the information from the previous assessment or reassessment is current.

(d) The assessment conducted under this section must:

(1) verify current assessed support needs;

(2) confirm continued need for the currently assessed level of care;

(3) inform the person of alternative long-term services and supports available;

(4) provide informed choice of institutional or home and community-based services; and

(5) identify changes in need that may require a full reassessment.

(e) The assessor must ensure that any new assessment items or requirements mandated by federal or state authority are addressed and the person must provide required information.

(f) The person has appeal rights under section 256.045, subdivision 3, if the assessor does not confirm that there are no changes in needs or services.

256B.0921 HOME AND COMMUNITY-BASED SERVICES INNOVATION POOL.

The commissioner of human services shall develop an initiative to provide incentives for innovation in: (1) achieving integrated competitive employment; (2) achieving integrated competitive employment for youth under age 25 upon their graduation from school; (3) living in the most integrated setting; and (4) other outcomes determined by the commissioner. The commissioner shall seek requests for proposals and shall contract with one or more entities to provide incentive payments for meeting identified outcomes.

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).

9505.2165 DEFINITIONS.

Subp. 4. **Fraud.** "Fraud" means:

A. acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes, including the following:

(1) theft in violation of Minnesota Statutes, section 609.52;

(2) perjury in violation of Minnesota Statutes, section 609.48;

(3) aggravated forgery and forgery in violation of Minnesota Statutes, sections 609.625 and 609.63;

(4) medical assistance fraud in violation of Minnesota Statutes, section 609.466; and

(5) financial transaction card fraud in violation of Minnesota Statutes, section 609.821;

B. making a false statement, false claim, or false representation to a program where the person knows or should reasonably know the statement, claim, or representation is false, including knowingly and willfully submitting a false or fraudulent application for provider status; and

C. a felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section 952.