CHAPTER 38--H.F.No. 2115

An act relating to human services; modifying policy provisions relating to aging and disability services, the Department of Health, Direct Care and Treatment, substance use disorder and behavioral health, the Department of Human Services Office of Inspector General, and certain health insurance claims; recodifying statutory language relating to assertive community treatment and intensive residential treatment services; modifying children's mental health terminology; requiring certain notifications regarding federal approval; making conforming changes; amending Minnesota Statutes 2024, sections 3.757, subdivision 1; 4.046, subdivisions 2, 3; 13.46, subdivisions 3, 4; 15.471, subdivision 6; 43A.241; 62J.495, subdivision 2; 62Q.527, subdivisions 1, 2, 3; 62Q.75, subdivision 3; 97A.441, subdivision 3; 121A.61, subdivision 3; 128C.02, subdivision 5; 142E.51, subdivisions 5, 6, by adding a subdivision; 142G.02, subdivision 56; 142G.27, subdivision 4; 142G.42, subdivision 3; 144.0724, subdivisions 2, 3a, 4, 8, 9, 11; 144.53; 144.651, subdivisions 2, 4, 10a, 20, 31, 32; 144A.07; 144A.071, subdivisions 4a, 4d; 144A.1888; 144A.61, by adding subdivisions; 144A.70, subdivisions 3, 7, by adding subdivisions; 144A.751, subdivision 1; 144G.08, by adding a subdivision; 144G.10, subdivisions 1, 1a, 5; 144G.16, subdivision 3; 144G.19, by adding a subdivision; 144G.45, by adding a subdivision; 144G.51; 144G.52, by adding a subdivision; 144G.53; 144G.70, subdivision 2; 144G.71, subdivisions 3, 5; 144G.81, subdivision 1; 144G.91, by adding a subdivision; 146A.08, subdivision 4; 147.091, subdivision 6; 147A.13, subdivision 6; 148.10, subdivision 1; 148.235, subdivision 10; 148.261, subdivision 5; 148.754; 148B.5905; 148F.09, subdivision 6; 148F.11, subdivision 1; 150A.08, subdivision 6; 151.071, subdivision 10; 153.21, subdivision 2; 153B.70; 168.012, subdivision 1; 169A.284; 244.052, subdivision 4; 245.462, subdivision 4; 245.4661, subdivision 9; 245.4662, subdivision 1; 245.4682, subdivision 3; 245.469; 245.481; 245.4835, subdivision 2; 245.4863; 245.487, subdivision 2; 245.4871, subdivisions 3, 4, 6, 13, 15, 17, 19, 21, 22, 28, 29, 31, 32, 34, by adding a subdivision; 245.4873, subdivision 2; 245.4874, subdivision 1; 245.4875, subdivision 5; 245.4876, subdivisions 4, 5; 245.4877; 245.488, subdivisions 1, 3; 245.4881, subdivisions 1, 3, 4; 245.4882, subdivisions 1, 5; 245.4884; 245.4885, subdivision 1; 245.4889, subdivision 1; 245.4901, subdivision 3; 245.4906, subdivision 2; 245.4907, subdivisions 2, 3; 245.491, subdivision 2; 245.492, subdivision 3; 245.50, subdivisions 2, 3, by adding a subdivision; 245.52; 245.697, subdivision 2a; 245.814, subdivision 3; 245.826; 245.91, subdivisions 2, 4; 245.92; 245.94, subdivision 1; 245A.03, subdivision 2; 245A.04, subdivisions 1, 7; 245A.16, subdivision 1; 245A.242, subdivision 2; 245A.26, subdivisions 1, 2; 245C.05, by adding a subdivision; 245C.08, subdivision 3; 245C.22, subdivision 5; 245D.02, subdivision 4a; 245D.091, subdivision 3; 245D.10, by adding a subdivision; 245F.06, subdivision 2; 245G.05, subdivision 1; 245G.06, subdivisions 1, 2a, 3a; 245G.07, subdivision 2; 245G.08, subdivision 6; 245G.09, subdivision 3; 245G.11, subdivisions 7, 11; 245G.18, subdivision 2; 245G.19, subdivision 4, by adding a subdivision; 245G.22, subdivisions 1, 14, 15; 245I.05, subdivisions 3, 5; 245I.06, subdivision 3; 245I.11, subdivision 5; 245I.12, subdivision 5; 246.585; 246C.06, subdivision 11; 246C.12, subdivisions 4, 6; 246C.20; 252.27, subdivision 1; 252.28, subdivision 2; 252.291, subdivision 3; 252.41, subdivision 3; 252.42; 252.43; 252.44; 252.45; 252.46, subdivision 1a; 252.50, subdivision 5; 253B.07, subdivision 2b; 253B.09, subdivision 3a; 253B.10, subdivision 1; 253B.141, subdivision 2; 253B.18, subdivision 6; 253B.19, subdivision 2; 253D.29, subdivisions 1, 2, 3; 253D.30, subdivisions 4, 5; 254A.03, subdivision 1; 254A.19, subdivisions 6, 7; 254B.04, subdivision 1a; 254B.05, subdivisions 1, 1a, 5; 254B.06, by adding a subdivision; 256.01, subdivisions 2, 5, 29, 34, by adding a subdivision; 256.019, subdivision 1; 256.0281; 256.0451, subdivisions 1, 3, 6, 8, 9, 18, 22, 23, 24; 256.478, subdivision 2; 256.4825; 256.93, subdivision 1; 256.9657, subdivision 7a; 256.98, subdivisions 1, 7; 256B.02, subdivision 11; 256B.055, subdivision

12; 256B.0615, subdivisions 1, 3; 256B.0616, subdivisions 1, 4, 5; 256B.0622, subdivisions 1, 3a, 7a, 8, 11, 12; 256B.064, subdivision 1a; 256B.0757, subdivision 2; 256B.0761, subdivision 4; 256B.092, subdivisions 1a, 10, 11, 11a; 256B.0943, subdivisions 1, 3, 9, 12, 13; 256B.0945, subdivision 1; 256B.0946, subdivision 6; 256B.0947, subdivision 3a; 256B.12; 256B.49, subdivisions 13, 29; 256B.4911, subdivision 6; 256B.4914, subdivisions 10a, 10d, 17; 256B.69, subdivision 23; 256B.77, subdivision 7a; 256B.82; 256D.44, subdivision 5; 256G.09, subdivisions 4, 5; 256I.04, subdivision 2c; 256L.03, subdivision 5; 256R.02, subdivisions 18, 19, 22; 256R.25; 256R.38; 256R.40, subdivision 5; 260B.157, subdivision 3; 260C.007, subdivisions 16, 26d, 27b; 260C.157, subdivision 3; 260C.201, subdivisions 1, 2; 260C.301, subdivision 4; 260D.01; 260D.02, subdivisions 5, 9; 260D.03, subdivision 1; 260D.04; 260D.06, subdivision 2; 260D.07; 260E.11, subdivision 3; 295.50, subdivision 9b; 299F.77, subdivision 2; 342.04; 352.91, subdivision 3f; 401.17, subdivision 1; 507.071, subdivision 1; 611.46, subdivision 1; 611.55, by adding a subdivision; 611.57, subdivisions 2, 4; 624.7131, subdivisions 1, 2; 624.7132, subdivisions 1, 2; 624.714, subdivisions 3, 4; 631.40, subdivision 3; Laws 2023, chapter 70, article 7, section 34; proposing coding for new law in Minnesota Statutes, chapters 245; 246C; 253B; 256B; 256R; 609; repealing Minnesota Statutes 2024, sections 144A.071, subdivision 4c; 144G.9999, subdivisions 1, 2, 3; 245.4862; 245A.042, subdivisions 2, 3, 4; 245A.11, subdivision 8; 246.015, subdivision 3; 246.50, subdivision 2; 246B.04, subdivision 1a; 256B.0622, subdivision 4; Laws 2024, chapter 79, article 1, sections 15; 16; 17; Minnesota Rules, part 9505.0250, subparts 1, 2, 3.

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

ARTICLE 1

AGING AND DISABILITY SERVICES

Section 1. Minnesota Statutes 2024, section 144.0724, subdivision 2, is amended to read:

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

(a) "Assessment reference date" or "ARD" means the specific end point for look-back periods in the MDS assessment process. This look-back period is also called the observation or assessment period.

(b) "Case mix index" means the weighting factors assigned to the case mix reimbursement classifications determined by an assessment.

(c) "Index maximization" means classifying a resident who could be assigned to more than one category, to the category with the highest case mix index.

(d) "Minimum Data Set" or "MDS" means a core set of screening, clinical assessment, and functional status elements, that include common definitions and coding categories specified by the Centers for Medicare and Medicaid Services and designated by the Department of Health.

(e) "Representative" means a person who is the resident's guardian or conservator, the person authorized to pay the nursing home expenses of the resident, a representative of the Office of Ombudsman for Long-Term Care whose assistance has been requested, or any other individual designated by the resident.

(f) "Activities of daily living" or "ADL" includes personal hygiene, dressing, bathing, transferring, bed mobility, locomotion, eating, and toileting.

(g) "Nursing facility level of care determination" means the assessment process that results in a determination of a resident's or prospective resident's need for nursing facility level of care as established in subdivision 11 for purposes of medical assistance payment of long-term care services for:

(1) nursing facility services under chapter 256R;

(2) elderly waiver services under chapter 256S;

(3) CADI and BI waiver services under section 256B.49; and

(4) state payment of alternative care services under section 256B.0913.

(h) "Patient Driven Payment Model" or "PDPM" means the case mix reimbursement classification system for residents in nursing facilities based on the resident's condition, diagnosis, and the care the resident received at the time of the MDS assessment with an ARD on or after October 1, 2025.

(i) "Resource utilization group" or "RUG" means the case mix reimbursement classification system for residents in nursing facilities according to the resident's clinical and functional status as reflected in data supplied by the facility's MDS with an ARD on or before September 30, 2025.

EFFECTIVE DATE. This section is effective October 1, 2025, and applies to assessments conducted on or after that date.

Sec. 2. Minnesota Statutes 2024, section 144A.071, subdivision 4a, is amended to read:

Subd. 4a. **Exceptions for replacement beds.** It is in the best interest of the state to ensure that nursing homes and boarding care homes continue to meet the physical plant licensing and certification requirements by permitting certain construction projects. Facilities should be maintained in condition to satisfy the physical and emotional needs of residents while allowing the state to maintain control over nursing home expenditure growth.

The commissioner of health in coordination with the commissioner of human services, may approve the renovation, replacement, upgrading, or relocation of a nursing home or boarding care home, under the following conditions:

(a) to license or certify beds in a new facility constructed to replace a facility or to make repairs in an existing facility that was destroyed or damaged after June 30, 1987, by fire, lightning, or other hazard provided:

(i) destruction was not caused by the intentional act of or at the direction of a controlling person of the facility;

(ii) at the time the facility was destroyed or damaged the controlling persons of the facility maintained insurance coverage for the type of hazard that occurred in an amount that a reasonable person would conclude was adequate;

(iii) the net proceeds from an insurance settlement for the damages caused by the hazard are applied to the cost of the new facility or repairs;

(iv) the number of licensed and certified beds in the new facility does not exceed the number of licensed and certified beds in the destroyed facility; and

(v) the commissioner determines that the replacement beds are needed to prevent an inadequate supply of beds.

Project construction costs incurred for repairs authorized under this clause shall not be considered in the dollar threshold amount defined in subdivision 2;

(b) to license or certify beds that are moved from one location to another within a nursing home facility, provided the total costs of remodeling performed in conjunction with the relocation of beds does not exceed $1,000,000;

(c) to license or certify beds in a project recommended for approval under section 144A.073;

(d) to license or certify beds that are moved from an existing state nursing home to a different state facility, provided there is no net increase in the number of state nursing home beds;

(e) to certify and license as nursing home beds boarding care beds in a certified boarding care facility if the beds meet the standards for nursing home licensure, or in a facility that was granted an exception to the moratorium under section 144A.073, and if the cost of any remodeling of the facility does not exceed $1,000,000. If boarding care beds are licensed as nursing home beds, the number of boarding care beds in the facility must not increase beyond the number remaining at the time of the upgrade in licensure. The provisions contained in section 144A.073 regarding the upgrading of the facilities do not apply to facilities that satisfy these requirements;

~~(f) to license and certify up to 40 beds transferred from an existing facility owned and operated by the Amherst H. Wilder Foundation in the city of St. Paul to a new unit at the same location as the existing facility that will serve persons with Alzheimer's disease and other related disorders. The transfer of beds may occur gradually or in stages, provided the total number of beds transferred does not exceed 40. At the time of licensure and certification of a bed or beds in the new unit, the commissioner of health shall delicense and decertify the same number of beds in the existing facility. As a condition of receiving a license or certification under this clause, the facility must make a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate as a result of the transfers allowed under this paragraph;~~

~~(g)~~ (f) to license and certify nursing home beds to replace currently licensed and certified boarding care beds which may be located either in a remodeled or renovated boarding care or nursing home facility or in a remodeled, renovated, newly constructed, or replacement nursing home facility within the identifiable complex of health care facilities in which the currently licensed boarding care beds are presently located, provided that the number of boarding care beds in the facility or complex are decreased by the number to be licensed as nursing home beds and further provided that, if the total costs of new construction, replacement, remodeling, or renovation exceed ten percent of the appraised value of the facility or $200,000, whichever is less, the facility makes a written commitment to the commissioner of human services that it will not seek to receive an increase in its property-related payment rate by reason of the new construction, replacement, remodeling, or renovation. The provisions contained in section 144A.073 regarding the upgrading of facilities do not apply to facilities that satisfy these requirements;

~~(h)~~ (g) to license as a nursing home and certify as a nursing facility a facility that is licensed as a boarding care facility but not certified under the medical assistance program, but only if the commissioner of human services certifies to the commissioner of health that licensing the facility as a nursing home and certifying the facility as a nursing facility will result in a net annual savings to the state general fund of $200,000 or more;

~~(i) to certify, after September 30, 1992, and prior to July 1, 1993, existing nursing home beds in a facility that was licensed and in operation prior to January 1, 1992;~~

~~(j) to license and certify new nursing home beds to replace beds in a facility acquired by the Minneapolis Community Development Agency as part of redevelopment activities in a city of the first class, provided the new facility is located within three miles of the site of the old facility. Operating and property costs for the new facility must be determined and allowed under section 256B.431 or 256B.434 or chapter 256R;~~

~~(k) to license and certify up to 20 new nursing home beds in a community-operated hospital and attached convalescent and nursing care facility with 40 beds on April 21, 1991, that suspended operation of the hospital in April 1986. The commissioner of human services shall provide the facility with the same per diem property-related payment rate for each additional licensed and certified bed as it will receive for its existing 40 beds;~~

~~(l)~~ (h) to license or certify beds in renovation, replacement, or upgrading projects as defined in section 144A.073, subdivision 1, so long as the cumulative total costs of the facility's remodeling projects do not exceed $1,000,000;

~~(m) to license and certify beds that are moved from one location to another for the purposes of converting up to five four-bed wards to single or double occupancy rooms in a nursing home that, as of January 1, 1993, was county-owned and had a licensed capacity of 115 beds;~~

~~(n) to allow a facility that on April 16, 1993, was a 106-bed licensed and certified nursing facility located in Minneapolis to layaway all of its licensed and certified nursing home beds. These beds may be relicensed and recertified in a newly constructed teaching nursing home facility affiliated with a teaching hospital upon approval by the legislature. The proposal must be developed in consultation with the interagency committee on long-term care planning. The beds on layaway status shall have the same status as voluntarily delicensed and decertified beds, except that beds on layaway status remain subject to the surcharge in section 256.9657. This layaway provision expires July 1, 1998;~~

~~(o) to allow a project which will be completed in conjunction with an approved moratorium exception project for a nursing home in southern Cass County and which is directly related to that portion of the facility that must be repaired, renovated, or replaced, to correct an emergency plumbing problem for which a state correction order has been issued and which must be corrected by August 31, 1993;~~

~~(p)~~ (i) to allow a facility that on April 16, 1993, was a 368-bed licensed and certified nursing facility located in Minneapolis to layaway, upon 30 days prior written notice to the commissioner, up to 30 of the facility's licensed and certified beds by converting three-bed wards to single or double occupancy. Beds on layaway status shall have the same status as voluntarily delicensed and decertified beds except that beds on layaway status remain subject to the surcharge in section 256.9657, remain subject to the license application and renewal fees under section 144A.07 and shall be subject to a $100 per bed reactivation fee~~. In addition, at any time within three years of the effective date of the layaway, the beds on layaway status may be:~~;

~~(1) relicensed and recertified upon relocation and reactivation of some or all of the beds to an existing licensed and certified facility or facilities located in Pine River, Brainerd, or International Falls; provided that the total project construction costs related to the relocation of beds from layaway status for any facility receiving relocated beds may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073;~~

~~(2) relicensed and recertified, upon reactivation of some or all of the beds within the facility which placed the beds in layaway status, if the commissioner has determined a need for the reactivation of the beds on layaway status.~~

~~The property-related payment rate of a facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for a facility relicensing and recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than three years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;~~

~~(q) to license and certify beds in a renovation and remodeling project to convert 12 four-bed wards into 24 two-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County; had a licensed capacity of 154 beds; and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;~~

~~(r) to license and certify up to 117 beds that are relocated from a licensed and certified 138-bed nursing facility located in St. Paul to a hospital with 130 licensed hospital beds located in South St. Paul, provided that the nursing facility and hospital are owned by the same or a related organization and that prior to the date the relocation is completed the hospital ceases operation of its inpatient hospital services at that hospital. After relocation, the nursing facility's status shall be the same as it was prior to relocation. The nursing facility's property-related payment rate resulting from the project authorized in this paragraph shall become effective no earlier than April 1, 1996. For purposes of calculating the incremental change in the facility's rental per diem resulting from this project, the allowable appraised value of the nursing facility portion of the existing health care facility physical plant prior to the renovation and relocation may not exceed $2,490,000;~~

~~(s) to license and certify two beds in a facility to replace beds that were voluntarily delicensed and decertified on June 28, 1991;~~

~~(t)~~ (j) to allow 16 licensed and certified beds located on July 1, 1994, in a 142-bed nursing home and 21-bed boarding care home facility in Minneapolis, notwithstanding the licensure and certification after July 1, 1995, of the Minneapolis facility as a 147-bed nursing home facility after completion of a construction project approved in 1993 under section 144A.073, to be laid away upon 30 days' prior written notice to the commissioner. Beds on layaway status shall have the same status as voluntarily delicensed or decertified beds except that they shall remain subject to the surcharge in section 256.9657~~. The 16 beds on layaway status may be relicensed as nursing home beds and recertified at any time within five years of the effective date of the layaway upon relocation of some or all of the beds to a licensed and certified facility located in Watertown, provided that the total project construction costs related to the relocation of beds from layaway status for the Watertown facility may not exceed the dollar threshold provided in subdivision 2 unless the construction project has been approved through the moratorium exception process under section 144A.073.~~;

~~The property-related payment rate of the facility placing beds on layaway status must be adjusted by the incremental change in its rental per diem after recalculating the rental per diem as provided in section 256B.431, subdivision 3a, paragraph (c). The property-related payment rate for the facility relicensing and~~

~~recertifying beds from layaway status must be adjusted by the incremental change in its rental per diem after recalculating its rental per diem using the number of beds after the relicensing to establish the facility's capacity day divisor, which shall be effective the first day of the month following the month in which the relicensing and recertification became effective. Any beds remaining on layaway status more than five years after the date the layaway status became effective must be removed from layaway status and immediately delicensed and decertified;~~

~~(u) to license and certify beds that are moved within an existing area of a facility or to a newly constructed addition which is built for the purpose of eliminating three- and four-bed rooms and adding space for dining, lounge areas, bathing rooms, and ancillary service areas in a nursing home that, as of January 1, 1995, was located in Fridley and had a licensed capacity of 129 beds;~~

~~(v) to relocate 36 beds in Crow Wing County and four beds from Hennepin County to a 160-bed facility in Crow Wing County, provided all the affected beds are under common ownership;~~

~~(w) to license and certify a total replacement project of up to 49 beds located in Norman County that are relocated from a nursing home destroyed by flood and whose residents were relocated to other nursing homes. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;~~

~~(x) to license and certify to the licensee of a nursing home in Polk County that was destroyed by flood in 1997 replacement projects with a total of up to 129 beds, with at least 25 beds to be located in Polk County and up to 104 beds distributed among up to three other counties. These beds may only be distributed to counties with fewer than the median number of age intensity adjusted beds per thousand, as most recently published by the commissioner of human services. If the licensee chooses to distribute beds outside of Polk County under this paragraph, prior to distributing the beds, the commissioner of health must approve the location in which the licensee plans to distribute the beds. The commissioner of health shall consult with the commissioner of human services prior to approving the location of the proposed beds. The licensee may combine these beds with beds relocated from other nursing facilities as provided in section 144A.073, subdivision 3e. The operating payment rates for the new nursing facilities shall be determined based on the interim and settle-up payment provisions of Minnesota Rules, parts 9549.0010 to 9549.0080. Property-related reimbursement rates shall be determined under section 256R.26. If the replacement beds permitted under this paragraph are combined with beds from other nursing facilities, the rates shall be calculated as the weighted average of rates determined as provided in this paragraph and section 256R.50;~~

~~(y) to license and certify beds in a renovation and remodeling project to convert 13 three-bed wards into 13 two-bed rooms and 13 single-bed rooms, expand space, and add improvements in a nursing home that, as of January 1, 1994, met the following conditions: the nursing home was located in Ramsey County, was not owned by a hospital corporation, had a licensed capacity of 64 beds, and had been ranked among the top 15 applicants by the 1993 moratorium exceptions advisory review panel. The total project construction cost estimate for this project must not exceed the cost estimate submitted in connection with the 1993 moratorium exception process;~~

~~(z) to license and certify up to 150 nursing home beds to replace an existing 285-bed nursing facility located in St. Paul. The replacement project shall include both the renovation of existing buildings and the construction of new facilities at the existing site. The reduction in the licensed capacity of the existing facility shall occur during the construction project as beds are taken out of service due to the construction process. Prior to the start of the construction process, the facility shall provide written information to the commissioner~~

~~of health describing the process for bed reduction, plans for the relocation of residents, and the estimated construction schedule. The relocation of residents shall be in accordance with the provisions of law and rule;~~

~~(aa) to allow the commissioner of human services to license an additional 36 beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 198-bed nursing home located in Red Wing, provided that the total number of licensed and certified beds at the facility does not increase;~~

~~(bb) to license and certify a new facility in St. Louis County with 44 beds constructed to replace an existing facility in St. Louis County with 31 beds, which has resident rooms on two separate floors and an antiquated elevator that creates safety concerns for residents and prevents nonambulatory residents from residing on the second floor. The project shall include the elimination of three- and four-bed rooms;~~

~~(cc)~~ (k) to license and certify four beds in a 16-bed certified boarding care home in Minneapolis to replace beds that were voluntarily delicensed and decertified on or before March 31, 1992. The licensure and certification is conditional upon the facility periodically assessing and adjusting its resident mix and other factors which may contribute to a potential institution for mental disease declaration. The commissioner of human services shall retain the authority to audit the facility at any time and shall require the facility to comply with any requirements necessary to prevent an institution for mental disease declaration, including delicensure and decertification of beds, if necessary;

~~(dd) to license and certify 72 beds in an existing facility in Mille Lacs County with 80 beds as part of a renovation project. The renovation must include construction of an addition to accommodate ten residents with beginning and midstage dementia in a self-contained living unit; creation of three resident households where dining, activities, and support spaces are located near resident living quarters; designation of four beds for rehabilitation in a self-contained area; designation of 30 private rooms; and other improvements;~~

~~(ee)~~ (l) to license and certify beds in a facility that has undergone replacement or remodeling as part of a planned closure under section 256R.40; or

~~(ff) to license and certify a total replacement project of up to 124 beds located in Wilkin County that are in need of relocation from a nursing home significantly damaged by flood. The operating cost payment rates for the new nursing facility shall be determined based on the interim and settle-up payment provisions of section 256R.27 and the reimbursement provisions of chapter 256R. Property-related reimbursement rates shall be determined under section 256R.26, taking into account any federal or state flood-related loans or grants provided to the facility;~~

~~(gg) to allow the commissioner of human services to license an additional nine beds to provide residential services for the physically disabled under Minnesota Rules, parts 9570.2000 to 9570.3400, in a 240-bed nursing home located in Duluth, provided that the total number of licensed and certified beds at the facility does not increase;~~

~~(hh) to license and certify up to 120 new nursing facility beds to replace beds in a facility in Anoka County, which was licensed for 98 beds as of July 1, 2000, provided the new facility is located within four miles of the existing facility and is in Anoka County. Operating and property rates shall be determined and allowed under chapter 256R and Minnesota Rules, parts 9549.0010 to 9549.0080; or~~

~~(ii) to transfer up to 98 beds of a 129-licensed bed facility located in Anoka County that, as of March 25, 2001, is in the active process of closing, to a 122-licensed bed nonprofit nursing facility located in the city of Columbia Heights or its affiliate. The transfer is effective when the receiving facility notifies the commissioner in writing of the number of beds accepted. The commissioner shall place all transferred beds~~

~~on layaway status held in the name of the receiving facility. The layaway adjustment provisions of section 256B.431, subdivision 30, do not apply to this layaway. The receiving facility may only remove the beds from layaway for recertification and relicensure at the receiving facility's current site, or at a newly constructed facility located in Anoka County. The receiving facility must receive statutory authorization before removing these beds from layaway status, or may remove these beds from layaway status if removal from layaway status is part of a moratorium exception project approved by the commissioner under section 144A.073.~~

(m) to license or certify beds under the provisions previously coded as Minnesota Statutes 2024, section 144A.071, subdivision 4a, paragraphs (f), (i) to (k), (m) to (bb), and (dd) to (ii).

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

Sec. 3. Minnesota Statutes 2024, section 144A.071, subdivision 4d, is amended to read:

Subd. 4d. **Consolidation of nursing facilities.** (a) The commissioner of health, in consultation with the commissioner of human services, may approve a request for net savings from a consolidation of nursing facilities ~~which includes~~ to be applied to reduce the costs of a moratorium exception project application under section 144A.073, subdivision 2. For purposes of this subdivision, "consolidation" means the closure of one or more facilities and the upgrading of the physical plant of the remaining nursing facility or facilities~~, the costs of which exceed the threshold project limit under subdivision 2, clause (a). The commissioners shall consider the criteria in this section, section 144A.073, and section 256R.40, in approving or rejecting a consolidation proposal. In the event the commissioners approve the request, the commissioner of human services shall calculate an external fixed costs rate adjustment according to clauses (1) to (3):~~.

~~(1) the closure of beds shall not be eligible for a planned closure rate adjustment under section 256R.40, subdivision 5;~~

~~(2) the construction project permitted in this clause shall not be eligible for a threshold project rate adjustment under section 256B.434, subdivision 4f, or a moratorium exception adjustment under section 144A.073; and~~

~~(3) the payment rate for external fixed costs for a remaining facility or facilities shall be increased by an amount equal to 65 percent of the projected net cost savings to the state calculated in paragraph (b), divided by the state's medical assistance percentage of medical assistance dollars, and then divided by estimated medical assistance resident days, as determined in paragraph (c), of the remaining nursing facility or facilities in the request in this paragraph. The rate adjustment is effective on the first day of the month of January or July, whichever date occurs first following both the completion of the construction upgrades in the consolidation plan and the complete closure of the facility or facilities designated for closure in the consolidation plan. If more than one facility is receiving upgrades in the consolidation plan, each facility's date of construction completion must be evaluated separately.~~

(b) For purposes of calculating the net ~~cost~~ savings ~~to the state~~, the commissioner shall consider clauses (1) to ~~(7)~~ (6):

(1) the annual savings from estimated medical assistance payments from the net number of beds closed taking into consideration only beds that are in active service on the date of the request and that have been in active service for at least three years;

(2) the estimated annual cost of increased case load of individuals receiving services under the elderly waiver;

(3) the estimated annual cost of elderly waiver recipients receiving support under housing support under chapter 256I;

(4) the estimated annual cost of increased case load of individuals receiving services under the alternative care program;

(5) the annual loss of license surcharge payments on closed beds; and

~~(6) the savings from not paying planned closure rate adjustments that the facilities would otherwise be eligible for under section 256R.40; and~~

~~(7)~~ (6) the savings from not ~~paying external fixed costs payment rate adjustments~~ providing a rate adjustment from submission of renovation costs that would otherwise be eligible as threshold projects under section 256B.434, subdivision 4f.

~~(c) For purposes of the calculation in paragraph (a), clause (3), the estimated medical assistance resident days of the remaining facility or facilities shall be computed assuming 95 percent occupancy multiplied by the historical percentage of medical assistance resident days of the remaining facility or facilities, as reported on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, multiplied by 365.~~

~~(d)~~ (c) For purposes of calculating net ~~cost of~~ savings ~~to the state~~ in paragraph (b), the average occupancy percentages will be those ~~reported~~ on the facility's or facilities' most recent nursing facility statistical and cost report filed before the plan of closure is submitted, and the average payment rates shall be calculated based on the approved payment rates in effect at the time the consolidation request is submitted.

~~(e) To qualify for the external fixed costs payment rate adjustment under this subdivision, the closing facilities shall:~~

~~(1) submit an application for closure according to section 256R.40, subdivision 2; and~~

~~(2) follow the resident relocation provisions of section 144A.161.~~

~~(f)~~ (d) The county or counties in which a facility or facilities are closed under this subdivision shall not be eligible for designation as a hardship area under subdivision 3 for five years from the date of the approval of the proposed consolidation. The applicant shall notify the county of this limitation and the county shall acknowledge this in a letter of support.

~~(g) Projects approved on or after March 1, 2020, are not subject to paragraph (a), clauses (2) and (3), and paragraph (e). The 65~~ (e) Sixty-five percent of the projected net ~~cost~~ savings ~~to the state~~ calculated in paragraph (b) must be applied to the moratorium cost of the project and the remainder must be added to the moratorium funding under section 144A.073, subdivision 11.

~~(h)~~ (f) Consolidation project applications not approved by the commissioner prior to March 1, 2020, are subject to the moratorium process under section 144A.073, subdivision 2. ~~Upon request by the applicant, the commissioner may extend this deadline to August 1, 2020, so long as the facilities, bed numbers, and counties specified in the original application are not altered. Proposals from facilities seeking approval for a consolidation project prior to March 1, 2020, must be received by the commissioner no later than January 1, 2020. This paragraph expires August 1, 2020.~~

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

Sec. 4. Minnesota Statutes 2024, section 144A.1888, is amended to read:

144A.1888 REUSE OF FACILITIES.

Notwithstanding any local ordinance related to development, planning, or zoning to the contrary, the conversion or reuse of a nursing home that closes or that curtails, reduces, or changes operations shall be considered a conforming use permitted under local law, provided that the facility is converted to another long-term care service ~~approved by a regional planning group under section 256R.40~~ that serves a smaller number of persons than the number of persons served before the closure or curtailment, reduction, or change in operations.

Sec. 5. Minnesota Statutes 2024, section 245D.091, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 6. Minnesota Statutes 2024, section 245D.10, is amended by adding a subdivision to read:

Subd. 1a. **Prohibited condition of service provision.** A license holder is prohibited from requiring a person to have or obtain a guardian or conservator as a condition of receiving or continuing to receive services regulated under this chapter.

Sec. 7. Minnesota Statutes 2024, section 252.28, subdivision 2, is amended to read:

Subd. 2. **Rules; program standards; licenses.** The commissioner of human services shall:

(1) Establish uniform rules and program standards for each type of residential and day facility or service for persons with developmental disabilities, including state hospitals under control of the executive board and serving persons with developmental disabilities, and excluding persons with developmental disabilities residing with their families.

(2) Grant licenses according to the provisions of ~~Laws 1976, chapter 243, sections 2 to 13~~ chapter 245A.

Sec. 8. Minnesota Statutes 2024, section 252.41, subdivision 3, is amended to read:

Subd. 3. **Day services for adults with disabilities.** (a) "Day services for adults with disabilities" or "day services" means services that:

(1) include supervision, training, assistance, support, facility-based work-related activities, or other community-integrated activities designed and implemented in accordance with the support plan and support plan addendum required under sections 245D.02, ~~subdivision 4, paragraphs (b) and (c),~~ subdivisions 4b and 4c, and 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12, to help an adult reach and maintain the highest possible level of independence, productivity, and integration into the community;

(2) include day support services, prevocational services, ~~day training and habilitation services,~~ structured day services, and adult day services as defined in Minnesota's federally approved disability waiver plans; ~~and~~

(3) include day training and habilitation services; and

(4) are provided by a vendor licensed under sections 245A.01 to 245A.16, 245D.27 to 245D.31, 252.28, subdivision 2, or 252.41 to 252.46, or Minnesota Rules, parts 9525.1200 to 9525.1330, to provide day services.

(b) Day services reimbursable under this section do not include special education and related services as defined in the Education of the Individuals with Disabilities Act, United States Code, title 20, chapter 33, section 1401, clauses (6) and (17), or vocational services funded under section 110 of the Rehabilitation Act of 1973, United States Code, title 29, section 720, as amended.

(c) Day services do not include employment exploration, employment development, or employment support services as defined in the home and community-based services waivers for people with disabilities authorized under sections 256B.092 and 256B.49.

Sec. 9. Minnesota Statutes 2024, section 252.42, is amended to read:

252.42 SERVICE PRINCIPLES.

The design and delivery of services eligible for reimbursement should reflect the following principles:

(1) services must suit a person's chronological age and be provided in the least restrictive environment possible, consistent with the needs identified in the person's support plan and support plan addendum required under sections 245D.02, subdivisions 4b and 4c, and 256B.092, subdivision 1b, ~~and 245D.02, subdivision 4, paragraphs (b) and (c),~~ and Minnesota Rules, part 9525.0004, subpart 12;

(2) a person with a disability whose individual support plans and support plan addendums authorize employment or employment-related activities shall be given the opportunity to participate in employment and employment-related activities in which nondisabled persons participate;

(3) a person with a disability participating in work shall be paid wages commensurate with the rate for comparable work and productivity except as regional centers are governed by section 246.151;

(4) a person with a disability shall receive services which include services offered in settings used by the general public and designed to increase the person's active participation in ordinary community activities;

(5) a person with a disability shall participate in the patterns, conditions, and rhythms of everyday living and working that are consistent with the norms of the mainstream of society.

Sec. 10. Minnesota Statutes 2024, section 252.43, is amended to read:

252.43 COMMISSIONER'S DUTIES.

(a) The commissioner shall supervise lead agencies' provision of day services to adults with disabilities. The commissioner shall:

(1) determine the need for day ~~programs~~ services, except for adult day services, under sections 256B.4914 and 252.41 to 252.46 operated in a day services facility licensed under sections 245D.27 to 245D.31;

~~(2) establish payment rates as provided under section 256B.4914;~~

~~(3)~~ (2) adopt rules for the administration and provision of day services under sections 245A.01 to 245A.16; 252.28, subdivision 2; or 252.41 to 252.46; or Minnesota Rules, parts 9525.1200 to 9525.1330;

~~(4)~~ (3) enter into interagency agreements necessary to ensure effective coordination and provision of day services;

~~(5)~~ (4) monitor and evaluate the costs and effectiveness of day services; and

~~(6)~~ (5) provide information and technical help to lead agencies and vendors in their administration and provision of day services.

(b) A determination of need in paragraph (a), clause (1), shall not be required for a change in day service provider name or ownership.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 11. Minnesota Statutes 2024, section 252.44, is amended to read:

252.44 LEAD AGENCY BOARD RESPONSIBILITIES.

When the need for day services in a county or tribe has been determined under section ~~252.28~~ 252.43, the board of commissioners for that lead agency shall:

(1) authorize the delivery of day services according to the support plans and support plan addendums required as part of the lead agency's provision of case management services under sections ~~256B.0913, subdivision 8;~~ 256B.092, subdivision 1b~~;~~, and 256B.49, subdivision 15~~;~~, and ~~256S.10 and~~ Minnesota Rules, parts 9525.0004 to 9525.0036;

(2) ensure that transportation is provided or arranged by the vendor in the most efficient and reasonable way possible; and

(3) monitor and evaluate the cost and effectiveness of the services.

Sec. 12. Minnesota Statutes 2024, section 252.45, is amended to read:

252.45 VENDOR'S DUTIES.

A day service vendor enrolled with the commissioner is responsible for items under clauses (1), (2), and (3), and extends only to the provision of services that are reimbursable under state and federal law. A vendor providing day services shall:

(1) provide the amount and type of services authorized in the individual service plan under the support plan and support plan addendum required under sections 245D.02, ~~subdivision 4, paragraphs (b) and (c)~~ subdivisions 4b and 4c, and 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12;

(2) design the services to achieve the outcomes assigned to the vendor in the support plan and support plan addendum required under sections 245D.02, ~~subdivision 4, paragraphs (a) and (b)~~ subdivisions 4b and 4c, and 256B.092, subdivision 1b, and Minnesota Rules, part 9525.0004, subpart 12;

(3) provide or arrange for transportation of persons receiving services to and from service sites;

(4) enter into agreements with community-based intermediate care facilities for persons with developmental disabilities to ensure compliance with applicable federal regulations; and

(5) comply with state and federal law.

Sec. 13. Minnesota Statutes 2024, section 252.46, subdivision 1a, is amended to read:

Subd. 1a. **Day training and habilitation rates.** (a) The commissioner shall establish ~~a statewide rate-setting methodology~~ rates for all day training and habilitation services ~~as provided under section 256B.4914. The rate-setting methodology must abide by the principles of transparency and equitability across the state. The methodology must involve a uniform process of structuring rates for each service and must promote quality and participant choice~~ and for transportation delivered as a part of day training and habilitation services.

(b) The commissioner shall consult with community partners prior to modifying rates under this subdivision.

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

Sec. 14. Minnesota Statutes 2024, section 256.01, subdivision 29, is amended to read:

Subd. 29. **State medical review team.** (a) To ensure the timely processing of determinations of disability by the commissioner's state medical review team under sections 256B.055, subdivisions 7, paragraph (b), and 12, and 256B.057, subdivision 9, the commissioner shall review all medical evidence and seek information from providers, applicants, and enrollees to support the determination of disability where necessary. Disability shall be determined according to the rules of title XVI and title XIX of the Social Security Act and pertinent rules and policies of the Social Security Administration.

(b) Medical assistance providers must grant the state medical review team access to electronic health records held by the medical assistance providers, when available, to support efficient and accurate disability determinations.

(c) Medical assistance providers shall accept electronically signed authorizations to release medical records provided by the state medical review team.

~~(b)~~ (d) Prior to a denial or withdrawal of a requested determination of disability due to insufficient evidence, the commissioner shall (1) ensure that the missing evidence is necessary and appropriate to a determination of disability, and (2) assist applicants and enrollees to obtain the evidence, including, but not limited to, medical examinations and electronic medical records.

~~(c)~~ (e) Any appeal made under section 256.045, subdivision 3, of a disability determination made by the state medical review team must be decided according to the timelines under section 256.0451, subdivision 22, paragraph (a). If a written decision is not issued within the timelines under section 256.0451, subdivision 22, paragraph (a), the appeal must be immediately reviewed by the chief human services judge.

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

Sec. 15. Minnesota Statutes 2024, section 256.9657, subdivision 7a, is amended to read:

Subd. 7a. **Withholding.** If any provider obligated to pay an annual surcharge under this section is more than two months delinquent in the timely payment of a monthly surcharge installment payment, the provisions in paragraphs (a) to (f) apply.

(a) The department may withhold some or all of the amount of the delinquent surcharge, together with any interest and penalties due and owing on those amounts, from any money the department owes to the provider. The department may, at its discretion, also withhold future surcharge installment payments from any money the department owes the provider as those installments become due and owing. The department may continue this withholding until the department determines there is no longer any need to do so.

(b) The department shall give prior notice of the department's intention to withhold by mailing or emailing a ~~written~~ notice to the provider at the address to which remittance advices are mailed, placing the notice in the provider's MN-ITS mailbox, or faxing a copy of the notice to the provider at least ten business days before the date of the first payment period for which the withholding begins. The notice may be sent by ordinary or certified mail, email, MN-ITS mailbox, or facsimile, and shall be deemed received as of the date of mailing or ~~receipt~~ issuance of the facsimile, email, MN-ITS mailbox, or distribution. The notice shall:

(1) state the amount of the delinquent surcharge;

(2) state the amount of the withholding per payment period;

(3) state the date on which the withholding is to begin;

(4) state whether the department intends to withhold future installments of the provider's surcharge payments;

(5) inform the provider of their rights to informally object to the proposed withholding and to appeal the withholding as provided for in this subdivision;

(6) state that the provider may prevent the withholding during the pendency of their appeal by posting a bond; and

(7) state other contents as the department deems appropriate.

(c) The provider may informally object to the withholding in writing anytime before the withholding begins. An informal objection shall not stay or delay the commencement of the withholding. The department may postpone the commencement of the withholding as deemed appropriate and shall not be required to give another notice at the end of the postponement and before commencing the withholding. The provider shall have the right to appeal any withholding from remittances by filing an appeal with Ramsey County District Court and serving notice of the appeal on the department within 30 days of the date of the written notice of the withholding. Notice shall be given and the appeal shall be heard no later than 45 days after the appeal is filed. In a hearing of the appeal, the department's action shall be sustained if the department proves the amount of the delinquent surcharges or overpayment the provider owes, plus any accrued interest and penalties, has not been repaid. The department may continue withholding for delinquent and current surcharge installment payments during the pendency of an appeal unless the provider posts a bond from a surety company licensed to do business in Minnesota in favor of the department in an amount equal to two times the provider's total annual surcharge payment for the fiscal year in which the appeal is filed with the department.

(d) The department shall refund any amounts due to the provider under any final administrative or judicial order or decree which fully and finally resolves the appeal together with interest on those amounts at the rate of three percent per annum simple interest computed from the date of each withholding, as soon as practical after entry of the order or decree.

(e) The commissioner, or the commissioner's designee, may enter into written settlement agreements with a provider to resolve disputes and other matters involving unpaid surcharge installment payments or future surcharge installment payments.

(f) Notwithstanding any law to the contrary, all unpaid surcharges, plus any accrued interest and penalties, shall be overpayments for purposes of section 256B.0641.

Sec. 16. Minnesota Statutes 2024, section 256B.092, subdivision 1a, is amended to read:

Subd. 1a. **Case management services.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application.

(b) Case management service activities provided to or arranged for a person include:

(1) development of the person-centered support plan under subdivision 1b;

(2) informing the individual or the individual's legal guardian or conservator, or parent if the person is a minor, of service options, including all service options available under the waiver plan;

(3) consulting with relevant medical experts or service providers;

(4) assisting the person in the identification of potential providers of chosen services, including:

(i) providers of services provided in a non-disability-specific setting;

(ii) employment service providers;

(iii) providers of services provided in settings that are not controlled by a provider; and

(iv) providers of financial management services;

(5) assisting the person to access services and assisting in appeals under section 256.045;

(6) coordination of services, if coordination is not provided by another service provider;

(7) evaluation and monitoring of the services identified in the support plan, which must incorporate at least one annual face-to-face visit by the case manager with each person; and

(8) reviewing support plans and providing the lead agency with recommendations for service authorization based upon the individual's needs identified in the support plan.

(c) Case management service activities that are provided to the person with a developmental disability shall be provided directly by county agencies or under contract. If a county agency contracts for case management services, the county agency must provide each recipient of home and community-based services who is receiving contracted case management services with the contact information the recipient may use to file a grievance with the county agency about the quality of the contracted services the recipient is receiving from a county-contracted case manager. If a county agency provides case management under contracts with other individuals or agencies and the county agency utilizes a competitive proposal process for the procurement of contracted case management services, the competitive proposal process must include evaluation criteria to ensure that the county maintains a culturally responsive program for case management services adequate to meet the needs of the population of the county. For the purposes of this section, "culturally responsive program" means a case management services program that: (1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs, practices, health literacy, preferred language, and other communication needs; and (2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background.

(d) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. Case management services must not be provided to a recipient by a private agency that has a financial interest in the provision of any other services included in the recipient's support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 10.

(e) Case managers are responsible for service provisions listed in paragraphs (a) and (b). Case managers shall collaborate with consumers, families, legal representatives, and relevant medical experts and service providers in the development and annual review of the person-centered support plan and habilitation plan.

(f) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case

manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(g) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than 20 hours of case management education and disability-related training each year. The education and training must include person-centered planning, informed choice, informed decision making, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. Case managers must annually complete an informed choice curriculum and pass a competency evaluation, in a form determined by the commissioner, on informed decision-making standards. By August 1, 2024, all case managers must complete an employment support training course identified by the commissioner of human services. For case managers hired after August 1, 2024, this training must be completed within the first six months of providing case management services. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 10. Case managers must document completion of training in a system identified by the commissioner.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 17. Minnesota Statutes 2024, section 256B.092, subdivision 11a, is amended to read:

Subd. 11a. **Residential support services criteria.** (a) For the purposes of this subdivision, "residential support services" means the following residential support services reimbursed under section 256B.4914: community residential services, customized living services, and 24-hour customized living services.

(b) In order to increase independent living options for people with disabilities and in accordance with section 256B.4905, subdivisions ~~3 and 4~~ 7 and 8, and consistent with section 245A.03, subdivision 7, the commissioner must establish and implement criteria to access residential support services. The criteria for accessing residential support services must prohibit the commissioner from authorizing residential support services unless at least all of the following conditions are met:

(1) the individual has complex behavioral health or complex medical needs; and

(2) the individual's service planning team has considered all other available residential service options and determined that those options are inappropriate to meet the individual's support needs.

(c) Nothing in this subdivision shall be construed as permitting the commissioner to establish criteria prohibiting the authorization of residential support services for individuals described in the statewide priorities established in subdivision 12, the transition populations in subdivision 13, and the licensing moratorium exception criteria under section 245A.03, subdivision 7, paragraph (a).

(d) Individuals with active service agreements for residential support services on the date that the criteria for accessing residential support services become effective are exempt from the requirements of this

subdivision, and the exemption from the criteria for accessing residential support services continues to apply for renewals of those service agreements.

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

Sec. 18. Minnesota Statutes 2024, section 256B.49, subdivision 13, is amended to read:

Subd. 13. **Case management.** (a) Each recipient of a home and community-based waiver shall be provided case management services by qualified vendors as described in the federally approved waiver application. The case management service activities provided must include:

(1) finalizing the person-centered written support plan within the timelines established by the commissioner and section 256B.0911, subdivision 29;

(2) informing the recipient or the recipient's legal guardian or conservator of service options, including all service options available under the waiver plans;

(3) assisting the recipient in the identification of potential service providers of chosen services, including:

(i) available options for case management service and providers;

(ii) providers of services provided in a non-disability-specific setting;

(iii) employment service providers;

(iv) providers of services provided in settings that are not community residential settings; and

(v) providers of financial management services;

(4) assisting the recipient to access services and assisting with appeals under section 256.045; and

(5) coordinating, evaluating, and monitoring of the services identified in the service plan.

(b) The case manager may delegate certain aspects of the case management service activities to another individual provided there is oversight by the case manager. The case manager may not delegate those aspects which require professional judgment including:

(1) finalizing the person-centered support plan;

(2) ongoing assessment and monitoring of the person's needs and adequacy of the approved person-centered support plan; and

(3) adjustments to the person-centered support plan.

(c) Case management services must be provided by a public or private agency that is enrolled as a medical assistance provider determined by the commissioner to meet all of the requirements in the approved federal waiver plans. If a county agency provides case management under contracts with other individuals or agencies and the county agency utilizes a competitive proposal process for the procurement of contracted case management services, the competitive proposal process must include evaluation criteria to ensure that the county maintains a culturally responsive program for case management services adequate to meet the needs of the population of the county. For the purposes of this section, "culturally responsive program" means a case management services program that: (1) ensures effective, equitable, comprehensive, and respectful quality care services that are responsive to individuals within a specific population's values, beliefs,

practices, health literacy, preferred language, and other communication needs; and (2) is designed to address the unique needs of individuals who share a common language or racial, ethnic, or social background.

(d) Case management services must not be provided to a recipient by a private agency that has any financial interest in the provision of any other services included in the recipient's support plan. For purposes of this section, "private agency" means any agency that is not identified as a lead agency under section 256B.0911, subdivision 10.

(e) For persons who need a positive support transition plan as required in chapter 245D, the case manager shall participate in the development and ongoing evaluation of the plan with the expanded support team. At least quarterly, the case manager, in consultation with the expanded support team, shall evaluate the effectiveness of the plan based on progress evaluation data submitted by the licensed provider to the case manager. The evaluation must identify whether the plan has been developed and implemented in a manner to achieve the following within the required timelines:

(1) phasing out the use of prohibited procedures;

(2) acquisition of skills needed to eliminate the prohibited procedures within the plan's timeline; and

(3) accomplishment of identified outcomes.

If adequate progress is not being made, the case manager shall consult with the person's expanded support team to identify needed modifications and whether additional professional support is required to provide consultation.

(f) The Department of Human Services shall offer ongoing education in case management to case managers. Case managers shall receive no less than 20 hours of case management education and disability-related training each year. The education and training must include person-centered planning, informed choice, informed decision making, cultural competency, employment planning, community living planning, self-direction options, and use of technology supports. Case managers must annually complete an informed choice curriculum and pass a competency evaluation, in a form determined by the commissioner, on informed decision-making standards. By August 1, 2024, all case managers must complete an employment support training course identified by the commissioner of human services. For case managers hired after August 1, 2024, this training must be completed within the first six months of providing case management services. For the purposes of this section, "person-centered planning" or "person-centered" has the meaning given in section 256B.0911, subdivision 10. Case managers shall document completion of training in a system identified by the commissioner.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 19. Minnesota Statutes 2024, section 256B.49, subdivision 29, is amended to read:

Subd. 29. **Residential support services criteria.** (a) For the purposes of this subdivision, "residential support services" means the following residential support services reimbursed under section 256B.4914: community residential services, customized living services, and 24-hour customized living services.

(b) In order to increase independent living options for people with disabilities and in accordance with section 256B.4905, subdivisions ~~3 and 4~~ 7 and 8, and consistent with section 245A.03, subdivision 7, the commissioner must establish and implement criteria to access residential support services. The criteria for accessing residential support services must prohibit the commissioner from authorizing residential support services unless at least all of the following conditions are met:

(1) the individual has complex behavioral health or complex medical needs; and

(2) the individual's service planning team has considered all other available residential service options and determined that those options are inappropriate to meet the individual's support needs.

(c) Nothing in this subdivision shall be construed as permitting the commissioner to establish criteria prohibiting the authorization of residential support services for individuals described in the statewide priorities established in subdivision ~~12~~ 11a, the transition populations in subdivision ~~13~~ 24, and the licensing moratorium exception criteria under section 245A.03, subdivision 7, paragraph (a).

~~(c)~~ (d) Individuals with active service agreements for residential support services on the date that the criteria for accessing residential support services become effective are exempt from the requirements of this subdivision, and the exemption from the criteria for accessing residential support services continues to apply for renewals of those service agreements.

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

Sec. 20. Minnesota Statutes 2024, section 256B.4911, subdivision 6, is amended to read:

Subd. 6. **Services provided by parents and spouses.** (a) This subdivision limits medical assistance payments under the consumer-directed community supports option for personal assistance services provided by a parent to the parent's minor child or by a participant's spouse. This subdivision applies to the consumer-directed community supports option available under all of the following:

(1) alternative care program;

(2) brain injury waiver;

(3) community alternative care waiver;

(4) community access for disability inclusion waiver;

(5) developmental disabilities waiver; and

(6) elderly waiver.

(b) For the purposes of this subdivision, "parent" means a parent, stepparent, or legal guardian of a minor.

(c) If multiple parents are providing personal assistance services to their minor child or children, each parent may provide up to 40 hours of personal assistance services in any seven-day period regardless of the number of children served. The total number of hours of medical assistance home and community-based services provided by all of the parents must not exceed 80 hours in a seven-day period regardless of the number of children served.

(d) If only one parent is providing personal assistance services to a minor child or children, the parent may provide up to 60 hours of medical assistance home and community-based services in a seven-day period regardless of the number of children served.

(e) Subject to the hour limits in paragraphs (c) and (d), a parent may provide personal assistance services to a minor child while traveling temporarily out of state if the minor child has an assessed activity of daily living dependency requiring supervision, direction, cueing, or hands-on assistance.

(f) If a participant's spouse is providing personal assistance services, the spouse may provide up to 60 hours of medical assistance home and community-based services in a seven-day period.

~~(f)~~ (g) This subdivision must not be construed to permit an increase in the total authorized consumer-directed community supports budget for an individual.

EFFECTIVE DATE. This section is effective August 1, 2025, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 21. Minnesota Statutes 2024, section 256B.4914, subdivision 10a, is amended to read:

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

(1) worker wage costs;

(2) benefits paid;

(3) supervisor wage costs;

(4) executive wage costs;

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

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

(7) administrative costs paid;

(8) program costs paid;

(9) transportation costs paid;

(10) vacancy rates; and

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

(b) At least once in any five-year period, a provider must submit cost data for a fiscal year that ended not more than 18 months prior to the submission date. The commissioner shall provide each provider a 90-day notice prior to its submission due date. If a provider fails to submit required reporting data, the commissioner shall provide notice to providers that have not provided required data 30 days after the required submission date, and a second notice for providers who have not provided required data 60 days after the required submission date. The commissioner shall temporarily suspend payments to the provider if cost data is not received 90 days after the required submission date. Withheld payments shall be made once data is received by the commissioner.

(c) The commissioner shall conduct a random validation of data submitted under paragraph (a) to ensure data accuracy. The commissioner shall analyze cost documentation in paragraph (a) and provide recommendations for adjustments to cost components.

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

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

EFFECTIVE DATE. This section is effective retroactively from January 1, 2025.

Sec. 22. Minnesota Statutes 2024, section 256B.4914, subdivision 10d, is amended to read:

Subd. 10d. **Direct care staff; compensation.** (a) A provider paid with rates determined under subdivision 6 must use a minimum of 66 percent of the revenue generated by rates determined under that subdivision for direct care staff compensation.

(b) A provider paid with rates determined under subdivision 7 must use a minimum of 45 percent of the revenue generated by rates determined under that subdivision for direct care staff compensation.

(c) A provider paid with rates determined under subdivision 8 or 9 must use a minimum of 60 percent of the revenue generated by rates determined under those subdivisions for direct care staff compensation.

(d) Compensation under this subdivision includes:

(1) wages;

(2) taxes and workers' compensation;

(3) health insurance;

(4) dental insurance;

(5) vision insurance;

(6) life insurance;

(7) short-term disability insurance;

(8) long-term disability insurance;

(9) retirement spending;

(10) tuition reimbursement;

(11) wellness programs;

(12) paid vacation time;

(13) paid sick time; or

(14) other items of monetary value provided to direct care staff.

(e) This subdivision does not apply to a provider licensed as an assisted living facility by the commissioner of health under chapter 144G.

(f) This subdivision is effective January 1, 2029, and applies to services provided on or after that date.

EFFECTIVE DATE. This section is effective retroactively from January 1, 2025.

Sec. 23. Minnesota Statutes 2024, section 256B.4914, subdivision 17, is amended to read:

Subd. 17. **~~Stakeholder~~ Community consultation and ~~county~~ training.** (a) The commissioner shall continue consultation at regular intervals with the ~~existing stakeholder group~~ DWRS advisory committee established as part of the rate-setting methodology process and ~~others~~ other community partners, to gather input, concerns, and data, to assist in the implementation of the rate payment system, and to make pertinent information available to the public through the department's website.

(b) The commissioner shall offer training at least annually for county personnel responsible for administering the rate-setting framework in a manner consistent with this section.

(c) The commissioner shall maintain an online instruction manual explaining the rate-setting framework. The manual ~~shall~~ must be consistent with this section, and ~~shall~~ must be accessible to ~~all stakeholders including~~ recipients, representatives of recipients, county or Tribal agencies, and license holders.

(d) The commissioner shall not defer to the county or Tribal agency on matters of technical application of the rate-setting framework, and a county or Tribal agency ~~shall~~ must not set rates in a manner that conflicts with this section.

(e) The commissioner must consult with the DWRS advisory committee and other community partners as required under this subdivision to periodically review, update, and revise the format by which initiators of rate exception requests and lead agencies collect and submit information about individuals with exceptional needs under subdivision 14.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 24. Minnesota Statutes 2024, section 256R.02, subdivision 18, is amended to read:

Subd. 18. **Employer health insurance costs.** "Employer health insurance costs" means:

(1) premium expenses for group coverage;

(2) actual expenses incurred for self-insured plans, including actual claims paid, stop-loss premiums, and plan fees. Actual expenses incurred for self-insured plans does not include allowances for future funding unless the plan meets the ~~Medicare~~ provider reimbursement manual requirements for reporting on a premium basis when the ~~Medicare~~ provider reimbursement manual regulations define the actual costs; and

(3) employer contributions to employer-sponsored individual coverage health reimbursement arrangements as provided by Code of Federal Regulations, title 45, section 146.123, employee health reimbursement accounts, and health savings accounts.

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

Sec. 25. Minnesota Statutes 2024, section 256R.02, subdivision 19, is amended to read:

Subd. 19. **External fixed costs.** "External fixed costs" means ~~costs related to the nursing home surcharge under section 256.9657, subdivision 1; licensure fees under section 144.122; family advisory council fee under section 144A.33; scholarships under section 256R.37; planned closure rate adjustments under section~~

~~256R.40; consolidation rate adjustments under section 144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d; single-bed room incentives under section 256R.41; property taxes, special assessments, and payments in lieu of taxes; employer health insurance costs; quality improvement incentive payment rate adjustments under section 256R.39; performance-based incentive payments under section 256R.38; special dietary needs under section 256R.51; Public Employees Retirement Association employer costs; and border city rate adjustments under section 256R.481~~ the items described in section 256R.25.

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

Sec. 26. Minnesota Statutes 2024, section 256R.02, subdivision 22, is amended to read:

Subd. 22. **Fringe benefit costs.** "Fringe benefit costs" means the costs for group life~~,~~; dental~~,~~; workers' compensation~~,~~; short- and long-term disability~~,~~; long-term care insurance~~,~~; accident insurance~~,~~; supplemental insurance~~,~~; legal assistance insurance~~,~~; profit sharing~~,~~; child care costs~~,~~; health insurance costs not covered under subdivision 18, including costs associated with eligible part-time employee family members or retirees~~,~~; and pension and retirement plan contributions, except for the Public Employees Retirement Association costs.

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

Sec. 27. Minnesota Statutes 2024, section 256R.25, is amended to read:

256R.25 EXTERNAL FIXED COSTS PAYMENT RATE.

(a) The payment rate for external fixed costs is the sum of the amounts in paragraphs (b) to (p).

(b) For a facility licensed as a nursing home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day. For a facility licensed as both a nursing home and a boarding care home, the portion related to the provider surcharge under section 256.9657 is equal to $8.86 per resident day multiplied by the result of its number of nursing home beds divided by its total number of licensed beds.

(c) The portion related to the licensure fee under section 144.122, paragraph (d), is the amount of the fee divided by the sum of the facility's resident days.

(d) The portion related to development and education of resident and family advisory councils under section 144A.33 is $5 per resident day divided by 365.

(e) The portion related to scholarships is determined under section 256R.37.

(f) The portion related to planned closure rate adjustments is as determined under section 256R.40, subdivision 5, and Minnesota Statutes 2010, section 256B.436.

(g) The portion related to consolidation rate adjustments shall be as determined under section ~~144A.071, subdivisions 4c, paragraph (a), clauses (5) and (6), and 4d~~ 256R.405.

(h) The portion related to single-bed room incentives is as determined under section 256R.41.

(i) The portions related to real estate taxes, special assessments, and payments made in lieu of real estate taxes directly identified or allocated to the nursing facility are the allowable amounts divided by the sum of the facility's resident days. Allowable costs under this paragraph for payments made by a nonprofit nursing facility that are in lieu of real estate taxes shall not exceed the amount which the nursing facility would have paid to a city or township and county for fire, police, sanitation services, and road maintenance costs had real estate taxes been levied on that property for those purposes.

(j) The portion related to employer health insurance costs is the allowable costs divided by the sum of the facility's resident days.

(k) The portion related to the Public Employees Retirement Association is the allowable costs divided by the sum of the facility's resident days.

(l) The portion related to quality improvement incentive payment rate adjustments is the amount determined under section 256R.39.

(m) The portion related to performance-based incentive payments is the amount determined under section 256R.38.

(n) The portion related to special dietary needs is the amount determined under section 256R.51.

(o) The portion related to the rate adjustments for border city facilities is the amount determined under section 256R.481.

(p) The portion related to the rate adjustment for critical access nursing facilities is the amount determined under section 256R.47.

Sec. 28. Minnesota Statutes 2024, section 256R.38, is amended to read:

256R.38 PERFORMANCE-BASED INCENTIVE PAYMENTS.

The commissioner shall develop additional incentive-based payments of up to five percent above a facility's operating payment rate for achieving outcomes specified in a contract. The commissioner may solicit proposals and select those which, on a competitive basis, best meet the state's policy objectives. The commissioner shall limit the amount of any incentive payment and the number of contract amendments under this section to operate the incentive payments within funds appropriated for this purpose. The commissioner shall approve proposals through a memorandum of understanding which shall specify various levels of payment for various levels of performance. Incentive payments to facilities under this section shall be in the form of time-limited rate adjustments which shall be included in the external fixed costs payment rate under section 256R.25. In establishing the specified outcomes and related criteria, the commissioner shall consider the following state policy objectives:

(1) successful diversion or discharge of residents to the residents' prior home or other community-based alternatives;

(2) adoption of new technology to improve quality or efficiency;

(3) improved quality as measured in the Minnesota Nursing Home Report Card;

(4) reduced acute care costs; and

(5) any additional outcomes proposed by a nursing facility that the commissioner finds desirable.

Sec. 29. Minnesota Statutes 2024, section 256R.40, subdivision 5, is amended to read:

Subd. 5. **Planned closure rate adjustment.** (a) The commissioner shall calculate the amount of the planned closure rate adjustment available under subdivision 6 according to clauses (1) to (4):

(1) the amount available is the net reduction of nursing facility beds multiplied by $2,080;

(2) the total number of beds in the nursing facility or facilities receiving the planned closure rate adjustment must be identified;

(3) capacity days are determined by multiplying the number determined under clause (2) by 365; and

(4) the planned closure rate adjustment is the amount available in clause (1), divided by capacity days determined under clause (3).

(b) A planned closure rate adjustment under this section is effective on the first day of the month of January or July, whichever occurs immediately following completion of closure of the facility designated for closure in the application and becomes part of the nursing facility's external fixed costs payment rate.

(c) Upon the request of a closing facility, the commissioner must allow the facility a closure rate adjustment as provided under section 144A.161, subdivision 10.

(d) A facility that has received a planned closure rate adjustment may reassign it to another facility that is under the same ownership at any time within three years of its effective date. The amount of the adjustment is computed according to paragraph (a).

(e) If the per bed dollar amount specified in paragraph (a), clause (1), is increased, the commissioner shall recalculate planned closure rate adjustments for facilities that delicense beds under this section on or after July 1, 2001, to reflect the increase in the per bed dollar amount. The recalculated planned closure rate adjustment is effective from the date the per bed dollar amount is increased.

Sec. 30. **[256R.405] CONSOLIDATION RATES.**

Subdivision 1. **Consolidation rates; generally.** The external fixed costs payment rate for nursing facilities that have completed a state-approved consolidation project must include a consolidation rate adjustment. A facility's consolidation rate adjustment expires upon transition to a fair rental value property payment rate under section 256R.26, subdivision 9. The commissioner must inform the revisor of statutes when a facility's consolidation rate adjustment specified under this section expires. This subdivision expires upon the expiration of all other subdivisions of this section.

Subd. 2. **Owatonna.** The consolidation rate for the nursing facility located at 2255 30th Street Northwest in Owatonna is $33.88.

Subd. 3. **Red Wing.** The consolidation rate for the nursing facility located at 213 Pioneer Road in Red Wing is $73.69.

Subd. 4. **White Bear Lake.** The consolidation rate for the nursing facility located at 1891 Florence Street in White Bear Lake is $25.56.

Subd. 5. **St. Paul.** The consolidation rate for the nursing facility located at 200 Earl Street in St. Paul is $68.01.

Subd. 6. **Cambridge.** The consolidation rate for the nursing facility located at 135 Fern Street North in Cambridge is $24.30.

Subd. 7. **Maple Plain.** The consolidation rate for the nursing facility located at 4848 Gateway Boulevard in Maple Plain is $38.76.

Subd. 8. **Maplewood.** The consolidation rate for the nursing facility located at 1438 County Road C East in Maplewood is $55.63.

Subd. 9. **Apple Valley.** The consolidation rate for the nursing facility located at 14650 Garrett Avenue in Apple Valley is $26.99.

Sec. 31. **REPEALER.**

Minnesota Statutes 2024, section 144A.071, subdivision 4c, is repealed.

ARTICLE 2

DEPARTMENT OF HEALTH POLICY

Section 1. Minnesota Statutes 2024, section 144.0724, subdivision 3a, is amended to read:

Subd. 3a. **Resident case mix reimbursement classifications.** (a) Resident case mix reimbursement classifications shall be based on the Minimum Data Set, version 3.0 assessment instrument, or its successor version mandated by the Centers for Medicare and Medicaid Services that nursing facilities are required to complete for all residents. Case mix reimbursement classifications shall also be based on assessments required under subdivision 4. Assessments must be completed according to the Long Term Care Facility Resident Assessment Instrument User's Manual Version 3.0 or a successor manual issued by the Centers for Medicare and Medicaid Services. ~~The optional state assessment must be completed according to the OSA Manual Version 1.0 v.2.~~

(b) Each resident must be classified based on the information from the Minimum Data Set according to the general categories issued by the Minnesota Department of Health, utilized for reimbursement purposes.

EFFECTIVE DATE. This section is effective October 1, 2025, and applies to assessments conducted on or after that date.

Sec. 2. Minnesota Statutes 2024, section 144.0724, subdivision 4, is amended to read:

Subd. 4. **Resident assessment schedule.** (a) A facility must conduct and electronically submit to the federal database MDS assessments that conform with the assessment schedule defined by the Long Term Care Facility Resident Assessment Instrument User's Manual, version 3.0, or its successor issued by the Centers for Medicare and Medicaid Services. The commissioner of health may substitute successor manuals or question and answer documents published by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services, to replace or supplement the current version of the manual or document.

(b) The assessments required ~~under the Omnibus Budget Reconciliation Act of 1987 (OBRA) used~~ to determine a case mix reimbursement classification include:

(1) a new admission comprehensive assessment, which must have an assessment reference date (ARD) within 14 calendar days after admission, excluding readmissions;

(2) an annual comprehensive assessment, which must have an ARD within 92 days of a previous quarterly review assessment or a previous comprehensive assessment, which must occur at least once every 366 days;

(3) a significant change in status comprehensive assessment, which must have an ARD within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition, whether an improvement or a decline, and regardless of the amount of time since the last comprehensive assessment or quarterly review assessment;

(4) a significant change in status comprehensive assessment when isolation for an infectious disease has ended. If isolation was not coded on the most recent assessment completed prior to isolation ending, then the significant change in status comprehensive assessment under this clause is not required. The ARD for assessments under this clause must be set on day 15 after isolation has ended;

(5) a quarterly review assessment must have an ARD within 92 days of the ARD of the previous quarterly review assessment or a previous comprehensive assessment;

~~(5)~~ (6) any significant correction to a prior comprehensive assessment, if the assessment being corrected is the current one being used for reimbursement classification;

~~(6)~~ (7) any significant correction to a prior quarterly review assessment, if the assessment being corrected is the current one being used for reimbursement classification; and

~~(7)~~ (8) any modifications to the most recent assessments under clauses (1) to ~~(6)~~ (7).

~~(c) The optional state assessment must accompany all OBRA assessments. The optional state assessment is also required to determine reimbursement when:~~

~~(1) all speech, occupational, and physical therapies have ended. If the most recent optional state assessment completed does not result in a rehabilitation case mix reimbursement classification, then the optional state assessment is not required. The ARD of this assessment must be set on day eight after all therapy services have ended; and~~

~~(2) isolation for an infectious disease has ended. If isolation was not coded on the most recent optional state assessment completed, then the optional state assessment is not required. The ARD of this assessment must be set on day 15 after isolation has ended.~~

~~(d)~~ (c) In addition to the assessments listed in ~~paragraphs~~ paragraph (b) ~~and (c)~~, the assessments used to determine nursing facility level of care include the following:

(1) preadmission screening completed under section 256.975, subdivisions 7a to 7c, by the Senior LinkAge Line or other organization under contract with the Minnesota Board on Aging; and

(2) a nursing facility level of care determination as provided for under section 256B.0911, subdivision 26, as part of a face-to-face long-term care consultation assessment completed under section 256B.0911, by a county, tribe, or managed care organization under contract with the Department of Human Services.

EFFECTIVE DATE. This section is effective October 1, 2025, and applies to assessments conducted on or after that date.

Sec. 3. Minnesota Statutes 2024, section 144.0724, subdivision 8, is amended to read:

Subd. 8. **Request for reconsideration of resident classifications.** (a) The resident, the resident's representative, the nursing facility, or the boarding care home may request that the commissioner of health reconsider the assigned case mix reimbursement classification and any item or items changed during the audit process. The request for reconsideration must be submitted in writing to the commissioner of health.

(b) For reconsideration requests initiated by the resident or the resident's representative:

(1) The resident or the resident's representative must submit in writing a reconsideration request to the facility administrator within 30 days of receipt of the resident classification notice. The written request must include the reasons for the reconsideration request.

(2) Within three business days of receiving the reconsideration request, the nursing facility must submit to the commissioner of health a completed reconsideration request form, a copy of the resident's or resident's representative's written request, and all supporting documentation used to complete the assessment being reconsidered. If the facility fails to provide the required information, the reconsideration will be completed with the information submitted and the facility cannot make further reconsideration requests on this classification.

(3) Upon written request and within three business days, the nursing facility must give the resident or the resident's representative a copy of the assessment being reconsidered and all supporting documentation used to complete the assessment. Notwithstanding any law to the contrary, the facility may not charge a fee for providing copies of the requested documentation. If a facility fails to provide the required documents within this time, it is subject to the issuance of a correction order and penalty assessment under sections 144.653 and 144A.10. Notwithstanding those sections, any correction order issued under this subdivision must require that the nursing facility immediately comply with the request for information, and as of the date of the issuance of the correction order, the facility shall forfeit to the state a $100 fine for the first day of noncompliance, and an increase in the $100 fine by $50 increments for each day the noncompliance continues.

(c) For reconsideration requests initiated by the facility:

(1) The facility is required to inform the resident or the resident's representative in writing that a reconsideration of the resident's case mix reimbursement classification is being requested. The notice must inform the resident or the resident's representative:

(i) of the date and reason for the reconsideration request;

(ii) of the potential for a case mix reimbursement classification change and subsequent rate change;

(iii) of the extent of the potential rate change;

(iv) that copies of the request and supporting documentation are available for review; and

(v) that the resident or the resident's representative has the right to request a reconsideration also.

(2) Within 30 days of receipt of the audit exit report or resident classification notice, the facility must submit to the commissioner of health a completed reconsideration request form, all supporting documentation used to complete the assessment being reconsidered, and a copy of the notice informing the resident or the resident's representative that a reconsideration of the resident's classification is being requested.

(3) If the facility fails to provide the required information, the reconsideration request may be denied and the facility may not make further reconsideration requests on this classification.

(d) Reconsideration by the commissioner must be made by individuals not involved in reviewing the assessment, audit, or reconsideration that established the disputed classification. The reconsideration must be based upon the assessment that determined the classification and upon the information provided to the commissioner of health under paragraphs (a) to (c). If necessary for evaluating the reconsideration request, the commissioner may conduct on-site reviews. Within 15 business days of receiving the request for reconsideration, the commissioner shall affirm or modify the original resident classification. The original classification must be modified if the commissioner determines that the assessment resulting in the classification did not accurately reflect characteristics of the resident at the time of the assessment. The commissioner must transmit the reconsideration classification notice by electronic means to the nursing facility. The nursing facility is responsible for the distribution of the notice to the resident or the resident's

representative. The notice must be distributed by the nursing facility within three business days after receipt. A decision by the commissioner under this subdivision is the final administrative decision of the agency for the party requesting reconsideration.

(e) The case mix reimbursement classification established by the commissioner shall be the classification which applies to the resident while the request for reconsideration is pending. If a request for reconsideration applies to an assessment used to determine nursing facility level of care under subdivision 4, paragraph ~~(d)~~ (c), the resident shall continue to be eligible for nursing facility level of care while the request for reconsideration is pending.

(f) The commissioner may request additional documentation regarding a reconsideration necessary to make an accurate reconsideration determination.

(g) Data collected as part of the reconsideration process under this section is classified as private data on individuals and nonpublic data pursuant to section 13.02. Notwithstanding the classification of these data as private or nonpublic, the commissioner is authorized to share these data with the U.S. Centers for Medicare and Medicaid Services and the commissioner of human services as necessary for reimbursement purposes.

EFFECTIVE DATE. This section is effective October 1, 2025, and applies to assessments conducted on or after that date.

Sec. 4. Minnesota Statutes 2024, section 144.0724, subdivision 9, is amended to read:

Subd. 9. **Audit authority.** (a) The commissioner shall audit the accuracy of resident assessments performed under section 256R.17 through any of the following: desk audits; on-site review of residents and their records; and interviews with staff, residents, or residents' families. The commissioner shall reclassify a resident if the commissioner determines that the resident was incorrectly classified.

(b) The commissioner is authorized to conduct on-site audits on an unannounced basis.

(c) A facility must grant the commissioner access to examine the medical records relating to the resident assessments selected for audit under this subdivision. The commissioner may also observe and speak to facility staff and residents.

(d) The commissioner shall consider documentation under the time frames for coding items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment Instrument User's Manual ~~or OSA Manual version 1.0 v.2 published by the Centers for Medicare and Medicaid Services~~.

(e) The commissioner shall develop an audit selection procedure that includes the following factors:

(1) Each facility shall be audited annually. If a facility has two successive audits in which the percentage of change is five percent or less and the facility has not been the subject of a special audit in the past 36 months, the facility may be audited biannually. A stratified sample of 15 percent, with a minimum of ten assessments, of the most current assessments shall be selected for audit. If more than 20 percent of the case mix reimbursement classifications are changed as a result of the audit, the audit shall be expanded to a second 15 percent sample, with a minimum of ten assessments. If the total change between the first and second samples is 35 percent or greater, the commissioner may expand the audit to all of the remaining assessments.

(2) If a facility qualifies for an expanded audit, the commissioner may audit the facility again within six months. If a facility has two expanded audits within a 24-month period, that facility will be audited at least every six months for the next 18 months.

(3) The commissioner may conduct special audits if the commissioner determines that circumstances exist that could alter or affect the validity of case mix reimbursement classifications of residents. These circumstances include, but are not limited to, the following:

(i) frequent changes in the administration or management of the facility;

(ii) an unusually high percentage of residents in a specific case mix reimbursement classification;

(iii) a high frequency in the number of reconsideration requests received from a facility;

(iv) frequent adjustments of case mix reimbursement classifications as the result of reconsiderations or audits;

(v) a criminal indictment alleging provider fraud;

(vi) other similar factors that relate to a facility's ability to conduct accurate assessments;

(vii) an atypical pattern of scoring minimum data set items;

(viii) nonsubmission of assessments;

(ix) late submission of assessments; or

(x) a previous history of audit changes of 35 percent or greater.

(f) If the audit results in a case mix reimbursement classification change, the commissioner must transmit the audit classification notice by electronic means to the nursing facility within 15 business days of completing an audit. The nursing facility is responsible for distribution of the notice to each resident or the resident's representative. This notice must be distributed by the nursing facility within three business days after receipt. The notice must inform the resident of the case mix reimbursement classification assigned, the opportunity to review the documentation supporting the classification, the opportunity to obtain clarification from the commissioner, the opportunity to request a reconsideration of the classification, and the address and telephone number of the Office of Ombudsman for Long-Term Care.

EFFECTIVE DATE. This section is effective October 1, 2025, and applies to assessments conducted on or after that date.

Sec. 5. Minnesota Statutes 2024, 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, ~~paragraphs~~ paragraph (b) ~~and (c)~~, 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, subdivisions 17 to 21, 23, 24, 27, or 28, that occurred no more than 60 calendar days before the effective date of medical assistance eligibility for payment of long-term care services.

EFFECTIVE DATE. This section is effective October 1, 2025, and applies to assessments conducted on or after that date.

Sec. 6. Minnesota Statutes 2024, section 144.651, subdivision 10a, is amended to read:

Subd. 10a. **Designated support person ~~for pregnant patient or other patient~~.** (a) Subject to paragraph (c), a health care provider and a health care facility must allow, at a minimum, one designated support person chosen by a patient, including but not limited to a pregnant patient, to be physically present while the patient is receiving health care services including during a hospital stay. Subject to paragraph (c), a facility must allow, at a minimum, one designated support person chosen by the resident to be physically present with the resident at times of the resident's choosing while the resident resides at the facility.

(b) For purposes of this subdivision, "designated support person" means any person chosen by the patient or resident to provide comfort to the patient or resident, including but not limited to the patient's or resident's spouse, partner, family member, or another person related by affinity. Certified doulas and traditional midwives may not be counted toward the limit of one designated support person.

(c) A facility may restrict or prohibit the presence of a designated support person in treatment rooms, procedure rooms, and operating rooms when such a restriction or prohibition is strictly necessary to meet the appropriate standard of care. A facility may also restrict or prohibit the presence of a designated support person if the designated support person is acting in a violent or threatening manner toward others. A facility

may restrict the presence of a resident's designated support person to the extent necessary to ensure a designated support person who is not a facility resident is not living at the facility on a short-term or long-term basis. Any restriction or prohibition of a designated support person by the facility is subject to the facility's written internal grievance procedure required by subdivision 20.

(d) This subdivision does not apply to a patient or resident at a state-operated treatment program as defined in section 253B.02, subdivision 18d.

Sec. 7. Minnesota Statutes 2024, section 144A.61, is amended by adding a subdivision to read:

Subd. 3b. **Commissioner approval of curricula for medication administration.** The commissioner of health must review and approve curricula that meet the requirements in Minnesota Rules, part 4658.1360, subpart 2, item B, to train unlicensed personnel in medication administration. Significant updates or amendments, including but not limited to changes to the standards of practice to the curricula, must be approved by the commissioner.

Sec. 8. Minnesota Statutes 2024, section 144A.61, is amended by adding a subdivision to read:

Subd. 3c. **Approved curricula.** The commissioner must maintain a current list of acceptable medication administration curricula to be used for medication aide training programs for employees of nursing homes and certified boarding care homes on the department's website that are based on current best practice standards and meet the requirements of Minnesota Rules, part 4658.1360, subpart 2, item B.

Sec. 9. Minnesota Statutes 2024, section 144A.70, subdivision 3, is amended to read:

Subd. 3. **Controlling person.** "Controlling person" means a business entity or entities, officer, program administrator, or director, whose responsibilities include the management and decision-making authority to establish or control business policy and all other policies of a supplemental nursing services agency. Controlling person also means an individual who~~, directly or indirectly, beneficially owns an~~ has a direct ownership interest or indirect ownership interest in a corporation, partnership, or other business association that is ~~a controlling person~~ the registrant.

Sec. 10. Minnesota Statutes 2024, section 144A.70, is amended by adding a subdivision to read:

Subd. 3a. **Direct ownership interest.** "Direct ownership interest" means an individual or legal entity with at least five percent equity in capital, stock, or profits of the registrant or who is a member of a limited liability company of the registrant.

Sec. 11. Minnesota Statutes 2024, section 144A.70, is amended by adding a subdivision to read:

Subd. 4b. **Indirect ownership interest.** "Indirect ownership interest" means an individual or legal entity with a direct ownership interest in an entity that has a direct or indirect ownership interest of at least five percent in an entity that is a registrant.

Sec. 12. Minnesota Statutes 2024, section 144A.70, subdivision 7, is amended to read:

Subd. 7. **Oversight.** The commissioner is responsible for the oversight of supplemental nursing services agencies through ~~semiannual~~ unannounced surveys every two years and follow-up surveys, complaint investigations under sections 144A.51 to 144A.53, and other actions necessary to ensure compliance with sections 144A.70 to 144A.74.

Sec. 13. Minnesota Statutes 2024, section 144A.751, subdivision 1, is amended to read:

Subdivision 1. **Statement of rights.** An individual who receives hospice care has the right to:

(1) receive written information about rights in advance of receiving hospice care or during the initial evaluation visit before the initiation of hospice care, including what to do if rights are violated;

(2) receive care and services according to a suitable hospice plan of care and subject to accepted hospice care standards and to take an active part in creating and changing the plan and evaluating care and services;

(3) be told in advance of receiving care about the services that will be provided, the disciplines that will furnish care, the frequency of visits proposed to be furnished, other choices that are available, and the consequence of these choices, including the consequences of refusing these services;

(4) be told in advance, whenever possible, of any change in the hospice plan of care and to take an active part in any change;

(5) refuse services or treatment;

(6) know, in advance, any limits to the services available from a provider, and the provider's grounds for a termination of services;

(7) know in advance of receiving care whether the hospice services may be covered by health insurance, medical assistance, Medicare, or other health programs in which the individual is enrolled;

(8) receive, upon request, a good faith estimate of the reimbursement the provider expects to receive from the health plan company in which the individual is enrolled. A good faith estimate must also be made available at the request of an individual who is not enrolled in a health plan company. This payment information does not constitute a legally binding estimate of the cost of services;

(9) know that there may be other services available in the community, including other end of life services and other hospice providers, and know where to go for information about these services;

(10) choose freely among available providers and change providers after services have begun, within the limits of health insurance, medical assistance, Medicare, or other health programs;

(11) have personal, financial, and medical information kept private and be advised of the provider's policies and procedures regarding disclosure of such information;

(12) be allowed access to records and written information from records according to sections 144.291 to 144.298;

(13) be served by people who are properly trained and competent to perform their duties;

(14) be treated with courtesy and respect and to have the patient's property treated with respect;

(15) voice grievances regarding treatment or care that is, or fails to be, furnished or regarding the lack of courtesy or respect to the patient or the patient's property;

(16) be free from physical and verbal abuse;

(17) reasonable, advance notice of changes in services or charges, including at least ten days' advance notice of the termination of a service by a provider, except in cases where:

(i) the recipient of services engages in conduct that alters the conditions of employment between the hospice provider and the individual providing hospice services, or creates an abusive or unsafe work environment for the individual providing hospice services;

(ii) an emergency for the informal caregiver or a significant change in the recipient's condition has resulted in service needs that exceed the current service provider agreement and that cannot be safely met by the hospice provider; or

(iii) the recipient is no longer certified as terminally ill;

(18) a coordinated transfer when there will be a change in the provider of services;

(19) know how to contact an individual associated with the provider who is responsible for handling problems and to have the provider investigate and attempt to resolve the grievance or complaint;

(20) know the name and address of the state or county agency to contact for additional information or assistance;

(21) assert these rights personally, or have them asserted by the hospice patient's family when the patient has been judged incompetent, without retaliation; ~~and~~

(22) have pain and symptoms managed to the patient's desired level of comfort, including ensuring appropriate medications are readily available to the patient;

(23) revoke hospice election at any time; and

(24) receive curative treatment for any condition unrelated to the condition that qualified the individual for hospice, in collaboration with the hospice provider if possible, while remaining on hospice election.

Sec. 14. Minnesota Statutes 2024, section 144G.08, is amended by adding a subdivision to read:

Subd. 55a. **Registered nurse.** "Registered nurse" has the meaning given in section 148.171, subdivision 20.

Sec. 15. Minnesota Statutes 2024, section 144G.10, subdivision 1, is amended to read:

Subdivision 1. **License required.** (a)(1) Beginning August 1, 2021, no assisted living facility may operate in Minnesota unless it is licensed under this chapter.

(2) No facility or building on a campus may provide assisted living services until obtaining the required license under paragraphs (c) to (e).

(b) The licensee is legally responsible for the management, control, and operation of the facility, regardless of the existence of a management agreement or subcontract. Nothing in this chapter shall in any way affect the rights and remedies available under other law.

(c) Upon approving an application for an assisted living facility license, the commissioner shall issue a single license for each building that is operated by the licensee as an assisted living facility and is located at a separate address, except as provided under paragraph (d) or (e). If a portion of a licensed assisted living facility building is utilized by an unlicensed entity or an entity with a license type not granted under this chapter, the licensed assisted living facility must ensure there is at least a vertical two-hour fire barrier as defined by the National Fire Protection Association Standard 101, Life Safety Code, between any licensed

assisted living facility areas and unlicensed entity areas of the building and between the licensed assisted living facility areas and any licensed areas subject to another license type.

(d) Upon approving an application for an assisted living facility license, the commissioner may issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility. An assisted living facility license for a campus must identify the address and licensed resident capacity of each building located on the campus in which assisted living services are provided.

(e) Upon approving an application for an assisted living facility license, the commissioner may:

(1) issue a single license for two or more buildings on a campus that are operated by the same licensee as an assisted living facility with dementia care, provided the assisted living facility for dementia care license for a campus identifies the buildings operating as assisted living facilities with dementia care; or

(2) issue a separate assisted living facility with dementia care license for a building that is on a campus and that is operating as an assisted living facility with dementia care.

Sec. 16. Minnesota Statutes 2024, section 144G.10, subdivision 1a, is amended to read:

Subd. 1a. **Assisted living director license required.** Each assisted living facility must employ an assisted living director who is licensed or permitted by the Board of Executives for Long Term Services and Supports and affiliated as the director of record with the board.

Sec. 17. Minnesota Statutes 2024, section 144G.10, subdivision 5, is amended to read:

Subd. 5. **Protected title; restriction on use.** (a) Effective January 1, ~~2026~~ 2027, no person or entity may use the phrase "assisted living," whether alone or in combination with other words and whether orally or in writing, to: advertise; market; or otherwise describe, offer, or promote itself, or any housing, service, service package, or program that it provides within this state, unless the person or entity is a licensed assisted living facility that meets the requirements of this chapter. A person or entity entitled to use the phrase "assisted living" shall use the phrase only in the context of its participation that meets the requirements of this chapter.

(b) Effective January 1, ~~2026~~ 2027, the licensee's name for ~~a new~~ an assisted living facility may not include the terms "home care" or "nursing home."

Sec. 18. Minnesota Statutes 2024, section 144G.16, subdivision 3, is amended to read:

Subd. 3. **Licensure; termination or extension of provisional licenses.** (a) If the provisional licensee is in substantial compliance with the survey, the commissioner shall issue a facility license.

(b) If the provisional licensee is not in substantial compliance with the initial survey, the commissioner shall either: (1) not issue the facility license and terminate the provisional license; or (2) extend the provisional license for a period not to exceed 90 calendar days and apply conditions necessary to bring the facility into substantial compliance. If the provisional licensee is not in substantial compliance with the survey within the time period of the extension or if the provisional licensee does not satisfy the license conditions, the commissioner may deny the license.

(c) The owners and managerial officials of a provisional licensee whose license is denied are ineligible to apply for an assisted living facility license under this chapter for one year following the facility's closure date.

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

Subd. 5. **Change of ownership; existing contracts.** Following a change of ownership, the new licensee must honor the terms of an assisted living contract in effect at the time of the change of ownership until the end of the contract term.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to all assisted living contracts executed on or after January 1, 2026.

Sec. 20. Minnesota Statutes 2024, section 144G.45, is amended by adding a subdivision to read:

Subd. 8. **Exceptions.** To accommodate the needs of an aging population in Otter Tail County, a three-story building with Type IIIB construction located in Otter Tail County may apply for an assisted living license under section 144G.191. This subdivision expires December 31, 2025.

Sec. 21. Minnesota Statutes 2024, section 144G.51, is amended to read:

144G.51 ARBITRATION.

(a) An assisted living facility must clearly and conspicuously disclose, in writing in an assisted living contract, any arbitration provision in the contract that precludes, limits, or delays the ability of a resident from taking a civil action.

(b) An arbitration requirement provision must not include a choice of law or choice of venue provision. Assisted living contracts must adhere to Minnesota law and any other applicable federal or local law.

(c) An assisted living facility must not require any resident or the resident's representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility.

Sec. 22. Minnesota Statutes 2024, section 144G.52, is amended by adding a subdivision to read:

Subd. 5a. **Impermissible ground for termination.** (a) A facility must not terminate an assisted living contract on the ground that the resident changes from using private funds to using public funds to pay for housing or services if the facility has represented or advertised that the facility accepts public funds to cover the costs of housing or services or makes any similar representation regarding the ability of the resident to remain in the facility when the resident's private funds are exhausted.

(b) A resident must notify the facility of the resident's intention to apply for public assistance to pay for housing or services, or both, and must make a timely application to the appropriate government agency or agencies. The facility must inform the resident at the time the resident moves into the facility and once annually of the facility's policy regarding converting from using private funds to public funds to pay for housing or services, or both, and of the resident's obligation to notify the facility of the resident's intent to apply for public assistance and to make a timely application for public assistance.

(c) This subdivision does not prohibit a facility from terminating an assisted living contract for nonpayment according to subdivision 3, or for a violation of the assisted living contract according to subdivision 4.

(d) If a resident's application for public funds is not processed within 30 days, the resident may contact the Office of Ombudsman for Long-Term Care to facilitate timely completion of enrollment with the appropriate lead agency.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to all assisted living contracts executed on or after January 1, 2026.

Sec. 23. Minnesota Statutes 2024, section 144G.53, is amended to read:

144G.53 NONRENEWAL OF HOUSING.

Subdivision 1. **Notice or termination procedure.** (a) If a facility decides to not renew a resident's housing under a contract, the facility must either (1) provide the resident with 60 calendar days' notice of the nonrenewal and assistance with relocation planning, or (2) follow the termination procedure under section 144G.52.

(b) The notice must include the reason for the nonrenewal and contact information of the Office of Ombudsman for Long-Term Care and the Office of Ombudsman for Mental Health and Developmental Disabilities.

(c) A facility must:

(1) provide notice of the nonrenewal to the Office of Ombudsman for Long-Term Care; and

(2) for residents who receive home and community-based waiver services under chapter 256S and section 256B.49, provide notice to the resident's case manager~~;~~.

Subd. 2. **Prohibited ground for nonrenewal.** (a) A facility must not decline to renew a resident's housing under an assisted living contract on the ground that the resident changes from using private funds to using public funds to pay for housing if the facility has represented or advertised that the facility accepts public funds to cover the costs of housing or makes any similar representation regarding the ability of the resident to remain in the facility when the resident's private funds are exhausted.

(b) A resident must notify the facility of the resident's intention to apply for public assistance to pay for housing or services, or both, and must make a timely application to the appropriate government agency or agencies. The facility must inform the resident at the time the resident moves into the facility and once annually of the facility's policy regarding converting from using private funds to public funds to pay for housing or services, or both, and of the resident's obligation to notify the facility of the resident's intent to apply for public assistance and to make a timely application for public assistance.

(c) This subdivision does not prohibit a facility from terminating an assisted living contract for nonpayment according to section 144G.52, subdivision 3, or for a violation of the assisted living contract according to section 144G.52, subdivision 4.

(d) If a resident's application for public funds is not processed within 30 days, the resident may contact the Office of Ombudsman for Long-Term Care to facilitate timely completion of enrollment with the appropriate lead agency.

Subd. 3. **Requirements following notice.** If a facility provides notice of nonrenewal according to subdivision 1, the facility must:

~~(3)~~ (1) ensure a coordinated move to a safe location, as defined in section 144G.55, subdivision 2, that is appropriate for the resident;

~~(4)~~ (2) ensure a coordinated move to an appropriate service provider identified by the facility, if services are still needed and desired by the resident;

~~(5)~~ (3) consult and cooperate with the resident, legal representative, designated representative, case manager for a resident who receives home and community-based waiver services under chapter 256S and section 256B.49, relevant health professionals, and any other persons of the resident's choosing to make arrangements to move the resident, including consideration of the resident's goals; and

~~(6)~~ (4) prepare a written plan to prepare for the move.

Subd. 4. **Right to move to location of resident's choosing or to use provider of resident's choosing.** ~~(d)~~ A resident may decline to move to the location the facility identifies or to accept services from a service provider the facility identifies, and may instead choose to move to a location of the resident's choosing or receive services from a service provider of the resident's choosing within the timeline prescribed in the nonrenewal notice.

EFFECTIVE DATE. This section is effective January 1, 2026, and applies to all assisted living contracts executed on or after January 1, 2026.

Sec. 24. Minnesota Statutes 2024, section 144G.70, subdivision 2, is amended to read:

Subd. 2. **Initial reviews, assessments, and monitoring.** (a) Residents who are not receiving any assisted living services shall not be required to undergo an initial nursing assessment.

(b) An assisted living facility shall conduct a nursing assessment by a registered nurse of the physical and cognitive needs of the prospective resident and propose a temporary service plan prior to the date on which a prospective resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier. If necessitated by either the geographic distance between the prospective resident and the facility, or urgent or unexpected circumstances, the assessment may be conducted using telecommunication methods based on practice standards that meet the resident's needs and reflect person-centered planning and care delivery.

(c) Resident reassessment and monitoring must be conducted ~~no more than 14 calendar days after initiation of services. Ongoing resident reassessment and monitoring must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the last date of the assessment.~~ by a registered nurse:

(1) no more than 14 calendar days after initiation of services;

(2) as needed based on changes in the resident's needs; and

(3) at least every 90 calendar days.

(d) Sections of the reassessment and monitoring in paragraph (c) may be completed by a licensed practical nurse as allowed under the Nurse Practice Act in sections 148.171 to 148.285. A registered nurse must review the findings as part of the resident's reassessment.

~~(d)~~ (e) For residents only receiving assisted living services specified in section 144G.08, subdivision 9, clauses (1) to (5), the facility shall complete an individualized initial review of the resident's needs and preferences. The initial review must be completed within 30 calendar days of the start of services. Resident monitoring and review must be conducted as needed based on changes in the needs of the resident and cannot exceed 90 calendar days from the date of the last review.

~~(e)~~ (f) A facility must inform the prospective resident of the availability of and contact information for long-term care consultation services under section 256B.0911, prior to the date on which a prospective

resident executes a contract with a facility or the date on which a prospective resident moves in, whichever is earlier.

Sec. 25. Minnesota Statutes 2024, section 144G.71, subdivision 3, is amended to read:

Subd. 3. **Individualized medication monitoring and reassessment.** ~~The assisted living facility~~ A registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must monitor and reassess the resident's medication management services as needed under subdivision 2 when the resident presents with symptoms or other issues that may be medication-related and, at a minimum, annually.

Sec. 26. Minnesota Statutes 2024, section 144G.71, subdivision 5, is amended to read:

Subd. 5. **Individualized medication management plan.** (a) For each resident receiving medication management services, ~~the assisted living facility~~ a registered nurse, advanced practice registered nurse, or qualified staff delegated the task by a registered nurse must prepare and include in the service plan a written statement of the medication management services that will be provided to the resident. The facility must develop and maintain a current individualized medication management record for each resident based on the resident's assessment that must contain the following:

(1) a statement describing the medication management services that will be provided;

(2) a description of storage of medications based on the resident's needs and preferences, risk of diversion, and consistent with the manufacturer's directions;

(3) documentation of specific resident instructions relating to the administration of medications;

(4) identification of persons responsible for monitoring medication supplies and ensuring that medication refills are ordered on a timely basis;

(5) identification of medication management tasks that may be delegated to unlicensed personnel;

(6) procedures for staff notifying a registered nurse or appropriate licensed health professional when a problem arises with medication management services; and

(7) any resident-specific requirements relating to documenting medication administration, verifications that all medications are administered as prescribed, and monitoring of medication use to prevent possible complications or adverse reactions.

(b) The medication management record must be current and updated when there are any changes.

(c) Medication reconciliation must be completed when a licensed nurse, licensed health professional, or authorized prescriber is providing medication management.

Sec. 27. Minnesota Statutes 2024, section 144G.81, subdivision 1, is amended to read:

Subdivision 1. **Fire protection and physical environment.** An assisted living facility with dementia care ~~that has a secured dementia care unit~~ must meet the requirements of section 144G.45 and the following additional requirements:

(1) ~~a hazard vulnerability~~ an assessment ~~or~~ of safety ~~risk~~ risks must be performed on and around the property. The ~~hazards indicated~~ safety risks identified by the facility on the assessment must be ~~assessed~~

~~and~~ mitigated to protect the residents from harm. The mitigation efforts must be documented in the facility's records; and

(2) the facility shall be protected throughout by an approved supervised automatic sprinkler system by August 1, 2029.

Sec. 28. Minnesota Statutes 2024, section 144G.91, is amended by adding a subdivision to read:

Subd. 6a. **Designated support person.** (a) Subject to paragraph (c), an assisted living facility must allow, at a minimum, one designated support person chosen by the resident to be physically present with the resident at times of the resident's choosing while the resident resides at the facility.

(b) For purposes of this subdivision, "designated support person" means any person chosen by the resident to provide comfort to the resident, including but not limited to the resident's spouse, partner, family member, or another person related by affinity.

(c) A facility may restrict or prohibit the presence of a designated support person if the designated support person is acting in a violent or threatening manner toward others. A facility may restrict the presence of a resident's designated support person to the extent necessary to ensure a designated support person who is not a facility resident is not living at the facility on a short-term or long-term basis. If the facility restricts or prohibits a resident's designated support person from being present, the resident may file a complaint or inquiry with the facility according to subdivision 20, the Office of Ombudsman for Long-Term Care, or the Office of Ombudsman for Mental Health and Developmental Disabilities.

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

Sec. 29. Minnesota Statutes 2024, section 148.235, subdivision 10, is amended to read:

Subd. 10. **Administration of medications by unlicensed personnel in nursing facilities.** Notwithstanding the provisions of Minnesota Rules, part 4658.1360, subpart 2, a graduate of a foreign nursing school who has successfully completed an approved competency evaluation under the provisions of section 144A.61 is eligible to administer medications in a nursing facility upon completion of ~~a~~ any medication training program for unlicensed personnel approved by the commissioner of health under section 144A.61, subdivision 3b, or offered through a postsecondary educational institution, which meets the requirements specified in Minnesota Rules, part 4658.1360, subpart 2, item B.

Sec. 30. **REVISOR INSTRUCTION.**

The revisor of statutes must modify the section headnote for Minnesota Statutes, section 144G.81, to read "ADDITIONAL REQUIREMENTS FOR ASSISTED LIVING FACILITIES WITH DEMENTIA CARE AND ASSISTED LIVING FACILITIES WITH SECURED DEMENTIA CARE UNITS."

Sec. 31. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall renumber Minnesota Statutes, section 144A.70, subdivision 4a, as Minnesota Statutes, section 144A.70, subdivision 4c, and correct all cross-references.

(b) The revisor of statutes shall renumber Minnesota Statutes, section 144A.70, subdivision 7, as Minnesota Statutes, section 144A.714, and correct all cross-references.

Sec. 32. **REPEALER.**

Minnesota Statutes 2024, section 144G.9999, subdivisions 1, 2, and 3, are repealed.

ARTICLE 3

DIRECT CARE AND TREATMENT

Section 1. Minnesota Statutes 2024, section 13.46, subdivision 3, is amended to read:

Subd. 3. **Investigative data.** (a) Data on persons, including data on vendors of services, licensees, and applicants that is collected, maintained, used, or disseminated by the welfare system in an investigation, authorized by statute, and relating to the enforcement of rules or law are confidential data on individuals pursuant to section 13.02, subdivision 3, or protected nonpublic data not on individuals pursuant to section 13.02, subdivision 13, and shall not be disclosed except:

(1) pursuant to section 13.05;

(2) pursuant to statute or valid court order;

(3) to a party named in a civil or criminal proceeding, administrative or judicial, for preparation of defense;

(4) to an agent of the welfare system or an investigator acting on behalf of a county, state, or federal government, including a law enforcement officer or attorney in the investigation or prosecution of a criminal, civil, or administrative proceeding, unless the commissioner of human services ~~or~~; the commissioner of children, youth, and families; or the Direct Care and Treatment executive board determines that disclosure may compromise a Department of Human Services ~~or~~; Department of Children, Youth, and Families; or Direct Care and Treatment ongoing investigation; or

(5) to provide notices required or permitted by statute.

The data referred to in this subdivision shall be classified as public data upon submission to an administrative law judge or court in an administrative or judicial proceeding. Inactive welfare investigative data shall be treated as provided in section 13.39, subdivision 3.

(b) Notwithstanding any other provision in law, the commissioner of human services shall provide all active and inactive investigative data, including the name of the reporter of alleged maltreatment under section 626.557 or chapter 260E, to the ombudsman for mental health and developmental disabilities upon the request of the ombudsman.

(c) Notwithstanding paragraph (a) and section 13.39, the existence of an investigation by the commissioner of human services of possible overpayments of public funds to a service provider or recipient may be disclosed if the commissioner determines that it will not compromise the investigation.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 2. Minnesota Statutes 2024, section 13.46, subdivision 4, is amended to read:

Subd. 4. **Licensing data.** (a) As used in this subdivision:

(1) "licensing data" are all data collected, maintained, used, or disseminated by the welfare system pertaining to persons licensed or registered or who apply for licensure or registration or who formerly were licensed or registered under the authority of the commissioner of human services;

(2) "client" means a person who is receiving services from a licensee or from an applicant for licensure; and

(3) "personal and personal financial data" are Social Security numbers, identity of and letters of reference, insurance information, reports from the Bureau of Criminal Apprehension, health examination reports, and social/home studies.

(b)(1)(i) Except as provided in paragraph (c), the following data on applicants, license holders, certification holders, and former licensees are public: name, address, telephone number of licensees, email addresses except for family child foster care, date of receipt of a completed application, dates of licensure, licensed capacity, type of client preferred, variances granted, record of training and education in child care and child development, type of dwelling, name and relationship of other family members, previous license history, class of license, the existence and status of complaints, and the number of serious injuries to or deaths of individuals in the licensed program as reported to the commissioner of human services; the commissioner of children, youth, and families; the local social services agency; or any other county welfare agency. For purposes of this clause, a serious injury is one that is treated by a physician.

(ii) Except as provided in item (v), when a correction order, an order to forfeit a fine, an order of license suspension, an order of temporary immediate suspension, an order of license revocation, an order of license denial, or an order of conditional license has been issued, or a complaint is resolved, the following data on current and former licensees and applicants are public: the general nature of the complaint or allegations leading to the temporary immediate suspension; the substance and investigative findings of the licensing or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence of settlement negotiations; the record of informal resolution of a licensing violation; orders of hearing; findings of fact; conclusions of law; specifications of the final correction order, fine, suspension, temporary immediate suspension, revocation, denial, or conditional license contained in the record of licensing action; whether a fine has been paid; and the status of any appeal of these actions.

(iii) When a license denial under section 142A.15 or 245A.05 or a sanction under section 142B.18 or 245A.07 is based on a determination that a license holder, applicant, or controlling individual is responsible for maltreatment under section 626.557 or chapter 260E, the identity of the applicant, license holder, or controlling individual as the individual responsible for maltreatment is public data at the time of the issuance of the license denial or sanction.

(iv) When a license denial under section 142A.15 or 245A.05 or a sanction under section 142B.18 or 245A.07 is based on a determination that a license holder, applicant, or controlling individual is disqualified under chapter 245C, the identity of the license holder, applicant, or controlling individual as the disqualified individual is public data at the time of the issuance of the licensing sanction or denial. If the applicant, license holder, or controlling individual requests reconsideration of the disqualification and the disqualification is affirmed, the reason for the disqualification and the reason to not set aside the disqualification are private data.

(v) A correction order or fine issued to a child care provider for a licensing violation is private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9, if the correction order or fine is seven years old or older.

(2) For applicants who withdraw their application prior to licensure or denial of a license, the following data are public: the name of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, and the date of withdrawal of the application.

(3) For applicants who are denied a license, the following data are public: the name and address of the applicant, the city and county in which the applicant was seeking licensure, the dates of the commissioner's receipt of the initial application and completed application, the type of license sought, the date of denial of the application, the nature of the basis for the denial, the existence of settlement negotiations, the record of informal resolution of a denial, orders of hearings, findings of fact, conclusions of law, specifications of the final order of denial, and the status of any appeal of the denial.

(4) When maltreatment is substantiated under section 626.557 or chapter 260E and the victim and the substantiated perpetrator are affiliated with a program licensed under chapter 142B or 245A; the commissioner of human services; commissioner of children, youth, and families; local social services agency; or county welfare agency may inform the license holder where the maltreatment occurred of the identity of the substantiated perpetrator and the victim.

(5) Notwithstanding clause (1), for child foster care, only the name of the license holder and the status of the license are public if the county attorney has requested that data otherwise classified as public data under clause (1) be considered private data based on the best interests of a child in placement in a licensed program.

(c) The following are private data on individuals under section 13.02, subdivision 12, or nonpublic data under section 13.02, subdivision 9: personal and personal financial data on family day care program and family foster care program applicants and licensees and their family members who provide services under the license.

(d) The following are private data on individuals: the identity of persons who have made reports concerning licensees or applicants that appear in inactive investigative data, and the records of clients or employees of the licensee or applicant for licensure whose records are received by the licensing agency for purposes of review or in anticipation of a contested matter. The names of reporters of complaints or alleged violations of licensing standards under chapters 142B, 245A, 245B, 245C, and 245D, and applicable rules and alleged maltreatment under section 626.557 and chapter 260E, are confidential data and may be disclosed only as provided in section 260E.21, subdivision 4; 260E.35; or 626.557, subdivision 12b.

(e) Data classified as private, confidential, nonpublic, or protected nonpublic under this subdivision become public data if submitted to a court or administrative law judge as part of a disciplinary proceeding in which there is a public hearing concerning a license which has been suspended, immediately suspended, revoked, or denied.

(f) Data generated in the course of licensing investigations that relate to an alleged violation of law are investigative data under subdivision 3.

(g) Data that are not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report as defined in section 260E.03, or 626.5572, subdivision 18, are subject to the destruction provisions of sections 260E.35, subdivision 6, and 626.557, subdivision 12b.

(h) Upon request, not public data collected, maintained, used, or disseminated under this subdivision that relate to or are derived from a report of substantiated maltreatment as defined in section 626.557 or chapter 260E may be exchanged with the Department of Health for purposes of completing background

studies pursuant to section 144.057 and with the Department of Corrections for purposes of completing background studies pursuant to section 241.021.

(i) Data on individuals collected according to licensing activities under chapters 142B, 245A, and 245C, data on individuals collected by the commissioner of human services according to investigations under section 626.557 and chapters 142B, 245A, 245B, 245C, 245D, and 260E may be shared with the Department of Human Rights, the Department of Health, the Department of Corrections, the ombudsman for mental health and developmental disabilities, and the individual's professional regulatory board when there is reason to believe that laws or standards under the jurisdiction of those agencies may have been violated or the information may otherwise be relevant to the board's regulatory jurisdiction. Background study data on an individual who is the subject of a background study under chapter 245C for a licensed service for which the commissioner of human services ~~or~~; the commissioner of children, youth, and families; or the Direct Care and Treatment executive board is the license holder may be shared with the commissioner and the commissioner's delegate by the licensing division. Unless otherwise specified in this chapter, the identity of a reporter of alleged maltreatment or licensing violations may not be disclosed.

(j) In addition to the notice of determinations required under sections 260E.24, subdivisions 5 and 7, and 260E.30, subdivision 6, paragraphs (b), (c), (d), (e), and (f), if the commissioner of children, youth, and families or the local social services agency has determined that an individual is a substantiated perpetrator of maltreatment of a child based on sexual abuse, as defined in section 260E.03, and the commissioner or local social services agency knows that the individual is a person responsible for a child's care in another facility, the commissioner or local social services agency shall notify the head of that facility of this determination. The notification must include an explanation of the individual's available appeal rights and the status of any appeal. If a notice is given under this paragraph, the government entity making the notification shall provide a copy of the notice to the individual who is the subject of the notice.

(k) All not public data collected, maintained, used, or disseminated under this subdivision and subdivision 3 may be exchanged between the Department of Human Services, Licensing Division, and the Department of Corrections for purposes of regulating services for which the Department of Human Services and the Department of Corrections have regulatory authority.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 3. Minnesota Statutes 2024, section 15.471, subdivision 6, is amended to read:

Subd. 6. **Party.** (a) Except as modified by paragraph (b), "party" means a person named or admitted as a party, or seeking and entitled to be admitted as a party, in a court action or contested case proceeding, or a person admitted by an administrative law judge for limited purposes, and who is:

(1) an unincorporated business, partnership, corporation, association, or organization, having not more than 500 employees at the time the civil action was filed or the contested case proceeding was initiated; and

(2) an unincorporated business, partnership, corporation, association, or organization whose annual revenues did not exceed $7,000,000 at the time the civil action was filed or the contested case proceeding was initiated.

(b) "Party" also includes a partner, officer, shareholder, member, or owner of an entity described in paragraph (a), clauses (1) and (2).

(c) "Party" does not include a person providing services pursuant to licensure or reimbursement on a cost basis by the Department of Health ~~or~~, the Department of Human Services, or Direct Care and Treatment

when that person is named or admitted or seeking to be admitted as a party in a matter which involves the licensing or reimbursement rates, procedures, or methodology applicable to those services.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 4. Minnesota Statutes 2024, section 43A.241, is amended to read:

43A.241 INSURANCE CONTRIBUTIONS; FORMER EMPLOYEES.

(a) This section applies to a person who:

(1) was employed by the commissioner of corrections, the commissioner of human services, or the Direct Care and Treatment executive board;

(2) was covered by the correctional employee retirement plan under section 352.91 or the general state employees retirement plan of the Minnesota State Retirement System as defined in section 352.021;

(3) while employed under clause (1), was assaulted by:

(i) a person under correctional supervision for a criminal offense; or

(ii) a client or patient at the Minnesota Sex Offender Program, or at a state-operated forensic services program as defined in section 352.91, subdivision 3j; and

(4) as a direct result of the assault under clause (3), was determined to be totally and permanently physically disabled under laws governing the Minnesota State Retirement System.

(b) For a person to whom this section applies, the commissioner of corrections, the commissioner of human services, or the Direct Care and Treatment executive board, using existing budget resources, must continue to make the employer contribution for medical and dental benefits under the State Employee Group Insurance Program after the person terminates state service. If the person had dependent coverage at the time of terminating state service, employer contributions for dependent coverage also must continue under this section. The employer contributions must be in the amount of the employer contribution for active state employees at the time each payment is made. The employer contributions must continue until the person reaches age 65, provided the person makes the required employee contributions, in the amount required of an active state employee, at the time and in the manner specified by the commissioner ~~or executive board~~.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 5. Minnesota Statutes 2024, section 62J.495, subdivision 2, is amended to read:

Subd. 2. **E-Health Advisory Committee.** (a) The commissioner shall establish an e-Health Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the adoption and effective use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for clinical data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data;

(3) recommendations for encouraging use of innovative health care applications using information technology and systems to improve patient care and reduce the cost of care, including applications relating to disease management and personal health management that enable remote monitoring of patients' conditions, especially those with chronic conditions; and

(4) other related issues as requested by the commissioner.

(b) The members of the e-Health Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce; a representative of the Direct Care and Treatment executive board; and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the commissioner to fulfill the requirements of section 3013, paragraph (g), of the HITECH Act.

(c) This subdivision expires June 30, 2031.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 6. Minnesota Statutes 2024, section 97A.441, subdivision 3, is amended to read:

Subd. 3. **Angling; residents of state institutions.** The commissioner may issue a license, without a fee, to take fish by angling to a person that is a ward of the commissioner of human services and a resident of a state institution under the control of the Direct Care and Treatment executive board upon application by the commissioner of human services.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 7. Minnesota Statutes 2024, section 144.53, is amended to read:

144.53 FEES.

Each application for a license, or renewal thereof, to operate a hospital, sanitarium or other institution for the hospitalization or care of human beings, within the meaning of sections 144.50 to 144.56, except applications by the Minnesota Veterans Home, the ~~commissioner of human services~~ Direct Care and Treatment executive board for the licensing of state institutions, or ~~by~~ the administrator for the licensing of the University of Minnesota hospitals, shall be accompanied by a fee to be prescribed by the state commissioner of health pursuant to section 144.122. No fee shall be refunded. Licenses shall expire and shall be renewed as prescribed by the commissioner of health pursuant to section 144.122.

No license granted hereunder shall be assignable or transferable.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 8. Minnesota Statutes 2024, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is

admitted to a residential program as defined in ~~section 253C.01~~ paragraph (c). For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program.

(b) "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules, parts 9530.6510 to 9530.6590.

(c) "Residential program" means (1) a hospital-based primary treatment program that provides residential treatment to minors with emotional disturbance as defined by the Comprehensive Children's Mental Health Act in sections 245.487 to 245.4889, or (2) a facility licensed by the state under Minnesota Rules, parts 2960.0580 to 2960.0700, to provide services to minors on a 24-hour basis.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 9. Minnesota Statutes 2024, section 144.651, subdivision 4, is amended to read:

Subd. 4. **Information about rights.** Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs ~~as defined in section 253C.01~~, the written statement shall also describe the right of a person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for people who have communication disabilities and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 10. Minnesota Statutes 2024, section 144.651, subdivision 20, is amended to read:

Subd. 20. **Grievances.** Patients and residents shall be encouraged and assisted, throughout their stay in a facility or their course of treatment, to understand and exercise their rights as patients, residents, and citizens. Patients and residents may voice grievances and recommend changes in policies and services to facility staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge. Notice of the grievance procedure of the facility or program, as well as addresses and telephone numbers for the Office of Health Facility Complaints and the area nursing home ombudsman pursuant to the Older Americans Act, section 307(a)(12) shall be posted in a conspicuous place.

Every acute care inpatient facility, every residential program ~~as defined in section 253C.01~~, every nonacute care facility, and every facility employing more than two people that provides outpatient mental

health services shall have a written internal grievance procedure that, at a minimum, sets forth the process to be followed; specifies time limits, including time limits for facility response; provides for the patient or resident to have the assistance of an advocate; requires a written response to written grievances; and provides for a timely decision by an impartial decision maker if the grievance is not otherwise resolved. Compliance by hospitals, residential programs ~~as defined in section 253C.01~~ which are hospital-based primary treatment programs, and outpatient surgery centers with section 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed to be compliance with the requirement for a written internal grievance procedure.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 11. Minnesota Statutes 2024, section 144.651, subdivision 31, is amended to read:

Subd. 31. **Isolation and restraints.** A minor patient who has been admitted to a residential program ~~as defined in section 253C.01~~ has the right to be free from physical restraint and isolation except in emergency situations involving a likelihood that the patient will physically harm the patient's self or others. These procedures may not be used for disciplinary purposes, to enforce program rules, or for the convenience of staff. Isolation or restraint may be used only upon the prior authorization of a physician, advanced practice registered nurse, physician assistant, psychiatrist, or licensed psychologist, only when less restrictive measures are ineffective or not feasible and only for the shortest time necessary.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 12. Minnesota Statutes 2024, section 144.651, subdivision 32, is amended to read:

Subd. 32. **Treatment plan.** A minor patient who has been admitted to a residential program ~~as defined in section 253C.01~~ has the right to a written treatment plan that describes in behavioral terms the case problems, the precise goals of the plan, and the procedures that will be utilized to minimize the length of time that the minor requires inpatient treatment. The plan shall also state goals for release to a less restrictive facility and follow-up treatment measures and services, if appropriate. To the degree possible, the minor patient and the minor patient's parents or guardian shall be involved in the development of the treatment and discharge plan.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 13. Minnesota Statutes 2024, section 144A.07, is amended to read:

144A.07 FEES.

Each application for a license to operate a nursing home, or for a renewal of license, except an application by the Minnesota Veterans Home or the ~~commissioner of human services~~ Direct Care and Treatment executive board for the licensing of state institutions, shall be accompanied by a fee to be prescribed by the commissioner of health pursuant to section 144.122. No fee shall be refunded.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 14. Minnesota Statutes 2024, section 146A.08, subdivision 4, is amended to read:

Subd. 4. **Examination; access to medical data.** (a) If the commissioner has probable cause to believe that an unlicensed complementary and alternative health care practitioner has engaged in conduct prohibited by subdivision 1, paragraph (h), (i), (j), or (k), the commissioner may issue an order directing the practitioner

to submit to a mental or physical examination or substance use disorder evaluation. For the purpose of this subdivision, every unlicensed complementary and alternative health care practitioner is deemed to have consented to submit to a mental or physical examination or substance use disorder evaluation when ordered to do so in writing by the commissioner and further to have waived all objections to the admissibility of the testimony or examination reports of the health care provider performing the examination or evaluation on the grounds that the same constitute a privileged communication. Failure of an unlicensed complementary and alternative health care practitioner to submit to an examination or evaluation when ordered, unless the failure was due to circumstances beyond the practitioner's control, constitutes an admission that the unlicensed complementary and alternative health care practitioner violated subdivision 1, paragraph (h), (i), (j), or (k), based on the factual specifications in the examination or evaluation order and may result in a default and final disciplinary order being entered after a contested case hearing. An unlicensed complementary and alternative health care practitioner affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the practitioner can resume the provision of complementary and alternative health care practices with reasonable safety to clients. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the commissioner shall be used against an unlicensed complementary and alternative health care practitioner in any other proceeding.

(b) In addition to ordering a physical or mental examination or substance use disorder evaluation, the commissioner may, notwithstanding section 13.384; 144.651; 595.02; or any other law limiting access to medical or other health data, obtain medical data and health records relating to an unlicensed complementary and alternative health care practitioner without the practitioner's consent if the commissioner has probable cause to believe that a practitioner has engaged in conduct prohibited by subdivision 1, paragraph (h), (i), (j), or (k). The medical data may be requested from a provider as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the commissioner under this subdivision and is not liable in any action for damages for releasing the data requested by the commissioner if the data are released pursuant to a written request under this subdivision, unless the information is false and the person or organization giving the information knew or had reason to believe the information was false. Information obtained under this subdivision is private data under section 13.41.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 15. Minnesota Statutes 2024, section 147.091, subdivision 6, is amended to read:

Subd. 6. **Mental examination; access to medical data.** (a) If the board has probable cause to believe that a regulated person comes under subdivision 1, paragraph (1), it may direct the person to submit to a mental or physical examination. For the purpose of this subdivision every regulated person is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the ground that the same constitute a privileged communication. Failure of a regulated person to submit to an examination when directed constitutes an admission of the allegations against the person, unless the failure was due to circumstance beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A regulated person affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the person can resume the competent practice of the regulated profession with reasonable skill and safety to the public.

In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a regulated person in any other proceeding.

(b) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a regulated person or applicant without the person's or applicant's consent if the board has probable cause to believe that a regulated person comes under subdivision 1, paragraph (1). The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private under sections 13.01 to 13.87.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 16. Minnesota Statutes 2024, section 147A.13, subdivision 6, is amended to read:

Subd. 6. **Mental examination; access to medical data.** (a) If the board has probable cause to believe that a physician assistant comes under subdivision 1, clause (1), it may direct the physician assistant to submit to a mental or physical examination. For the purpose of this subdivision, every physician assistant licensed under this chapter is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the ground that the same constitute a privileged communication. Failure of a physician assistant to submit to an examination when directed constitutes an admission of the allegations against the physician assistant, unless the failure was due to circumstance beyond the physician assistant's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A physician assistant affected under this subdivision shall at reasonable intervals be given an opportunity to demonstrate that the physician assistant can resume competent practice with reasonable skill and safety to patients. In any proceeding under this subdivision, neither the record of proceedings nor the orders entered by the board shall be used against a physician assistant in any other proceeding.

(b) In addition to ordering a physical or mental examination, the board may, notwithstanding sections 13.384, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a licensee or applicant without the licensee's or applicant's consent if the board has probable cause to believe that a physician assistant comes under subdivision 1, clause (1).

The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private under chapter 13.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 17. Minnesota Statutes 2024, section 148.10, subdivision 1, is amended to read:

Subdivision 1. **Grounds.** (a) The state Board of Chiropractic Examiners may refuse to grant, or may revoke, suspend, condition, limit, restrict or qualify a license to practice chiropractic, or may cause the name

of a person licensed to be removed from the records in the office of the court administrator of the district court for:

(1) advertising that is false or misleading; that violates a rule of the board; or that claims the cure of any condition or disease;

(2) the employment of fraud or deception in applying for a license or in passing the examination provided for in section 148.06 or conduct which subverts or attempts to subvert the licensing examination process;

(3) the practice of chiropractic under a false or assumed name or the impersonation of another practitioner of like or different name;

(4) the conviction of a crime involving moral turpitude;

(5) the conviction, during the previous five years, of a felony reasonably related to the practice of chiropractic;

(6) habitual intemperance in the use of alcohol or drugs;

(7) practicing under a license which has not been renewed;

(8) advanced physical or mental disability;

(9) the revocation or suspension of a license to practice chiropractic; or other disciplinary action against the licensee; or the denial of an application for a license by the proper licensing authority of another state, territory or country; or failure to report to the board that charges regarding the person's license have been brought in another state or jurisdiction;

(10) the violation of, or failure to comply with, the provisions of sections 148.01 to 148.105, the rules of the state Board of Chiropractic Examiners, or a lawful order of the board;

(11) unprofessional conduct;

(12) being unable to practice chiropractic with reasonable skill and safety to patients by reason of illness, professional incompetence, senility, drunkenness, use of drugs, narcotics, chemicals or any other type of material, or as a result of any mental or physical condition, including deterioration through the aging process or loss of motor skills. If the board has probable cause to believe that a person comes within this clause, it shall direct the person to submit to a mental or physical examination. For the purpose of this clause, every person licensed under this chapter shall be deemed to have given consent to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the ground that the same constitute a privileged communication. Failure of a person to submit to such examination when directed shall constitute an admission of the allegations, unless the failure was due to circumstances beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A person affected under this clause shall at reasonable intervals be afforded an opportunity to demonstrate that the person can resume the competent practice of chiropractic with reasonable skill and safety to patients.

In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384, 144.651, or any other law limiting access to health data, obtain health data and health records relating to a licensee or applicant without the licensee's or applicant's consent if the board has probable cause to believe that a doctor of chiropractic comes under this clause. The health data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a government agency,

including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider or entity giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private under sections 13.01 to 13.87.

In any proceeding under this clause, neither the record of proceedings nor the orders entered by the board shall be used against a person in any other proceeding;

(13) aiding or abetting an unlicensed person in the practice of chiropractic, except that it is not a violation of this clause for a doctor of chiropractic to employ, supervise, or delegate functions to a qualified person who may or may not be required to obtain a license or registration to provide health services if that person is practicing within the scope of the license or registration or delegated authority;

(14) improper management of health records, including failure to maintain adequate health records as described in clause (18), to comply with a patient's request made under sections 144.291 to 144.298 or to furnish a health record or report required by law;

(15) failure to make reports required by section 148.102, subdivisions 2 and 5, or to cooperate with an investigation of the board as required by section 148.104, or the submission of a knowingly false report against another doctor of chiropractic under section 148.10, subdivision 3;

(16) splitting fees, or promising to pay a portion of a fee or a commission, or accepting a rebate;

(17) revealing a privileged communication from or relating to a patient, except when otherwise required or permitted by law;

(18) failing to keep written chiropractic records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, test results, and x-rays. Unless otherwise required by law, written records need not be retained for more than seven years and x-rays need not be retained for more than four years;

(19) exercising influence on the patient or client in such a manner as to exploit the patient or client for financial gain of the licensee or of a third party which shall include, but not be limited to, the promotion or sale of services, goods, or appliances;

(20) gross or repeated malpractice or the failure to practice chiropractic at a level of care, skill, and treatment which is recognized by a reasonably prudent chiropractor as being acceptable under similar conditions and circumstances; or

(21) delegating professional responsibilities to a person when the licensee delegating such responsibilities knows or has reason to know that the person is not qualified by training, experience, or licensure to perform them.

(b) For the purposes of paragraph (a), clause (2), conduct that subverts or attempts to subvert the licensing examination process includes, but is not limited to: (1) conduct that violates the security of the examination materials, such as removing examination materials from the examination room or having unauthorized possession of any portion of a future, current, or previously administered licensing examination; (2) conduct that violates the standard of test administration, such as communicating with another examinee during administration of the examination, copying another examinee's answers, permitting another examinee to

copy one's answers, or possessing unauthorized materials; or (3) impersonating an examinee or permitting an impersonator to take the examination on one's own behalf.

(c) For the purposes of paragraph (a), clauses (4) and (5), conviction as used in these subdivisions includes a conviction of an offense that if committed in this state would be deemed a felony without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned but the adjudication of guilt is either withheld or not entered.

(d) For the purposes of paragraph (a), clauses (4), (5), and (6), a copy of the judgment or proceeding under seal of the administrator of the court or of the administrative agency which entered the same shall be admissible into evidence without further authentication and shall constitute prima facie evidence of its contents.

(e) For the purposes of paragraph (a), clause (11), unprofessional conduct means any unethical, deceptive or deleterious conduct or practice harmful to the public, any departure from or the failure to conform to the minimal standards of acceptable chiropractic practice, or a willful or careless disregard for the health, welfare or safety of patients, in any of which cases proof of actual injury need not be established. Unprofessional conduct shall include, but not be limited to, the following acts of a chiropractor:

(1) gross ignorance of, or incompetence in, the practice of chiropractic;

(2) engaging in conduct with a patient that is sexual or may reasonably be interpreted by the patient as sexual, or in any verbal behavior that is seductive or sexually demeaning to a patient;

(3) performing unnecessary services;

(4) charging a patient an unconscionable fee or charging for services not rendered;

(5) directly or indirectly engaging in threatening, dishonest, or misleading fee collection techniques;

(6) perpetrating fraud upon patients, third-party payors, or others, relating to the practice of chiropractic, including violations of the Medicare or Medicaid laws or state medical assistance laws;

(7) advertising that the licensee will accept for services rendered assigned payments from any third-party payer as payment in full, if the effect is to give the impression of eliminating the need of payment by the patient of any required deductible or co-payment applicable in the patient's health benefit plan. As used in this clause, "advertise" means solicitation by the licensee by means of handbills, posters, circulars, motion pictures, radio, newspapers, television, or in any other manner. In addition to the board's power to punish for violations of this clause, violation of this clause is also a misdemeanor;

(8) accepting for services rendered assigned payments from any third-party payer as payment in full, if the effect is to eliminate the need of payment by the patient of any required deductible or co-payment applicable in the patient's health benefit plan, except as hereinafter provided; and

(9) any other act that the board by rule may define.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 18. Minnesota Statutes 2024, section 148.261, subdivision 5, is amended to read:

Subd. 5. **Examination; access to medical data.** The board may take the following actions if it has probable cause to believe that grounds for disciplinary action exist under subdivision 1, clause (9) or (10):

(a) It may direct the applicant or nurse to submit to a mental or physical examination or substance use disorder evaluation. For the purpose of this subdivision, when a nurse licensed under sections 148.171 to 148.285 is directed in writing by the board to submit to a mental or physical examination or substance use disorder evaluation, that person is considered to have consented and to have waived all objections to admissibility on the grounds of privilege. Failure of the applicant or nurse to submit to an examination when directed constitutes an admission of the allegations against the applicant or nurse, unless the failure was due to circumstances beyond the person's control, and the board may enter a default and final order without taking testimony or allowing evidence to be presented. A nurse affected under this paragraph shall, at reasonable intervals, be given an opportunity to demonstrate that the competent practice of professional, advanced practice registered, or practical nursing can be resumed with reasonable skill and safety to patients. Neither the record of proceedings nor the orders entered by the board in a proceeding under this paragraph, may be used against a nurse in any other proceeding.

(b) It may, notwithstanding sections 13.384, 144.651, 595.02, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a registered nurse, advanced practice registered nurse, licensed practical nurse, or applicant for a license without that person's consent. The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private data on individuals as defined in section 13.02.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 19. Minnesota Statutes 2024, section 148.754, is amended to read:

148.754 EXAMINATION; ACCESS TO MEDICAL DATA.

(a) If the board has probable cause to believe that a licensee comes under section 148.75, paragraph (a), clause (2), it may direct the licensee to submit to a mental or physical examination. For the purpose of this paragraph, every licensee is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the examining physicians' testimony or examination reports on the ground that they constitute a privileged communication. Failure of the licensee to submit to an examination when directed constitutes an admission of the allegations against the person, unless the failure was due to circumstances beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A licensee affected under this paragraph shall, at reasonable intervals, be given an opportunity to demonstrate that the person can resume the competent practice of physical therapy with reasonable skill and safety to the public.

(b) In any proceeding under paragraph (a), neither the record of proceedings nor the orders entered by the board shall be used against a licensee in any other proceeding.

(c) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a licensee or applicant without the person's or applicant's consent if the board has probable cause to believe that the person comes under paragraph (a). The medical data may be requested

from a provider, as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this paragraph and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this paragraph, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this paragraph is classified as private under sections 13.01 to 13.87.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 20. Minnesota Statutes 2024, section 148B.5905, is amended to read:

148B.5905 MENTAL, PHYSICAL, OR SUBSTANCE USE DISORDER EXAMINATION OR EVALUATION; ACCESS TO MEDICAL DATA.

(a) If the board has probable cause to believe section 148B.59, paragraph (a), clause (9), applies to a licensee or applicant, the board may direct the person to submit to a mental, physical, or substance use disorder examination or evaluation. For the purpose of this section, every licensee and applicant is deemed to have consented to submit to a mental, physical, or substance use disorder examination or evaluation when directed in writing by the board and to have waived all objections to the admissibility of the examining professionals' testimony or examination reports on the grounds that the testimony or examination reports constitute a privileged communication. Failure of a licensee or applicant to submit to an examination when directed by the board constitutes an admission of the allegations against the person, unless the failure was due to circumstances beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A licensee or applicant affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the person can resume the competent practice of licensed professional counseling with reasonable skill and safety to the public. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a licensee or applicant in any other proceeding.

(b) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a licensee or applicant without the licensee's or applicant's consent if the board has probable cause to believe that section 148B.59, paragraph (a), clause (9), applies to the licensee or applicant. The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (i); an insurance company; or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private under sections 13.01 to 13.87.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 21. Minnesota Statutes 2024, section 148F.09, subdivision 6, is amended to read:

Subd. 6. **Mental, physical, or chemical health evaluation.** (a) If the board has probable cause to believe that an applicant or licensee is unable to practice alcohol and drug counseling with reasonable skill

and safety due to a mental or physical illness or condition, the board may direct the individual to submit to a mental, physical, or chemical dependency examination or evaluation.

(1) For the purposes of this section, every licensee and applicant is deemed to have consented to submit to a mental, physical, or chemical dependency examination or evaluation when directed in writing by the board and to have waived all objections to the admissibility of the examining professionals' testimony or examination reports on the grounds that the testimony or examination reports constitute a privileged communication.

(2) Failure of a licensee or applicant to submit to an examination when directed by the board constitutes an admission of the allegations against the person, unless the failure was due to circumstances beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence.

(3) A licensee or applicant affected under this subdivision shall at reasonable intervals be given an opportunity to demonstrate that the licensee or applicant can resume the competent practice of licensed alcohol and drug counseling with reasonable skill and safety to the public.

(4) In any proceeding under this subdivision, neither the record of proceedings nor the orders entered by the board shall be used against the licensee or applicant in any other proceeding.

(b) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384 or sections 144.291 to 144.298, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a licensee or applicant without the licensee's or applicant's consent if the board has probable cause to believe that subdivision 1, clause (9), applies to the licensee or applicant. The medical data may be requested from:

(1) a provider, as defined in section 144.291, subdivision 2, paragraph (i);

(2) an insurance company; or

(3) a government agency, including the Department of Human Services and Direct Care and Treatment.

(c) A provider, insurance company, or government agency must comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false.

(d) Information obtained under this subdivision is private data on individuals as defined in section 13.02, subdivision 12.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 22. Minnesota Statutes 2024, section 150A.08, subdivision 6, is amended to read:

Subd. 6. **Medical records.** Notwithstanding contrary provisions of sections 13.384 and 144.651 or any other statute limiting access to medical or other health data, the board may obtain medical data and health records of a licensee or applicant without the licensee's or applicant's consent if the information is requested by the board as part of the process specified in subdivision 5. The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (h), an insurance company, or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this

subdivision and shall not be liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision shall be classified as private under the Minnesota Government Data Practices Act.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 23. Minnesota Statutes 2024, section 151.071, subdivision 10, is amended to read:

Subd. 10. **Mental examination; access to medical data.** (a) If the board receives a complaint and has probable cause to believe that an individual licensed or registered by the board falls under subdivision 2, clause (14), it may direct the individual to submit to a mental or physical examination. For the purpose of this subdivision, every licensed or registered individual is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and further to have waived all objections to the admissibility of the examining practitioner's testimony or examination reports on the grounds that the same constitute a privileged communication. Failure of a licensed or registered individual to submit to an examination when directed constitutes an admission of the allegations against the individual, unless the failure was due to circumstances beyond the individual's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. Pharmacists affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that they can resume the competent practice of the profession of pharmacy with reasonable skill and safety to the public. Pharmacist interns, pharmacy technicians, or controlled substance researchers affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that they can competently resume the duties that can be performed, under this chapter or the rules of the board, by similarly registered persons with reasonable skill and safety to the public. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a licensed or registered individual in any other proceeding.

(b) Notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, the board may obtain medical data and health records relating to an individual licensed or registered by the board, or to an applicant for licensure or registration, without the individual's consent when the board receives a complaint and has probable cause to believe that the individual is practicing in violation of subdivision 2, clause (14), and the data and health records are limited to the complaint. The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false. Information obtained under this subdivision is classified as private under sections 13.01 to 13.87.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 24. Minnesota Statutes 2024, section 153.21, subdivision 2, is amended to read:

Subd. 2. **Access to medical data.** In addition to ordering a physical or mental examination or substance use disorder evaluation, the board may, notwithstanding section 13.384, 144.651, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a licensee or applicant without the licensee's or applicant's consent if the board has probable cause to believe that a doctor of

podiatric medicine falls within the provisions of section 153.19, subdivision 1, clause (12). The medical data may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph (h), an insurance company, or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this section and is not liable in any action for damages for releasing the data requested by the board if the data are released in accordance with a written request under this section, unless the information is false and the provider giving the information knew, or had reason to believe, the information was false.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 25. Minnesota Statutes 2024, section 153B.70, is amended to read:

153B.70 GROUNDS FOR DISCIPLINARY ACTION.

(a) The board may refuse to issue or renew a license, revoke or suspend a license, or place on probation or reprimand a licensee for one or any combination of the following:

(1) making a material misstatement in furnishing information to the board;

(2) violating or intentionally disregarding the requirements of this chapter;

(3) conviction of a crime, including a finding or verdict of guilt, an admission of guilt, or a no-contest plea, in this state or elsewhere, reasonably related to the practice of the profession. Conviction, as used in this clause, includes a conviction of an offense which, if committed in this state, would be deemed a felony, gross misdemeanor, or misdemeanor, without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilty is made or returned but the adjudication of guilt is either withheld or not entered;

(4) making a misrepresentation in order to obtain or renew a license;

(5) displaying a pattern of practice or other behavior that demonstrates incapacity or incompetence to practice;

(6) aiding or assisting another person in violating the provisions of this chapter;

(7) failing to provide information within 60 days in response to a written request from the board, including documentation of completion of continuing education requirements;

(8) engaging in dishonorable, unethical, or unprofessional conduct;

(9) engaging in conduct of a character likely to deceive, defraud, or harm the public;

(10) inability to practice due to habitual intoxication, addiction to drugs, or mental or physical illness;

(11) being disciplined by another state or territory of the United States, the federal government, a national certification organization, or foreign nation, if at least one of the grounds for the discipline is the same or substantially equivalent to one of the grounds in this section;

(12) directly or indirectly giving to or receiving from a person, firm, corporation, partnership, or association a fee, commission, rebate, or other form of compensation for professional services not actually or personally rendered;

(13) incurring a finding by the board that the licensee, after the licensee has been placed on probationary status, has violated the conditions of the probation;

(14) abandoning a patient or client;

(15) willfully making or filing false records or reports in the course of the licensee's practice including, but not limited to, false records or reports filed with state or federal agencies;

(16) willfully failing to report child maltreatment as required under the Maltreatment of Minors Act, chapter 260E; or

(17) soliciting professional services using false or misleading advertising.

(b) A license to practice is automatically suspended if (1) a guardian of a licensee is appointed by order of a court pursuant to sections 524.5-101 to 524.5-502, for reasons other than the minority of the licensee, or (2) the licensee is committed by order of a court pursuant to chapter 253B. The license remains suspended until the licensee is restored to capacity by a court and, upon petition by the licensee, the suspension is terminated by the board after a hearing. The licensee may be reinstated to practice, either with or without restrictions, by demonstrating clear and convincing evidence of rehabilitation. The regulated person is not required to prove rehabilitation if the subsequent court decision overturns previous court findings of public risk.

(c) If the board has probable cause to believe that a licensee or applicant has violated paragraph (a), clause (10), it may direct the person to submit to a mental or physical examination. For the purpose of this section, every person is deemed to have consented to submit to a mental or physical examination when directed in writing by the board and to have waived all objections to the admissibility of the examining physician's testimony or examination report on the grounds that the testimony or report constitutes a privileged communication. Failure of a regulated person to submit to an examination when directed constitutes an admission of the allegations against the person, unless the failure was due to circumstances beyond the person's control, in which case a default and final order may be entered without the taking of testimony or presentation of evidence. A regulated person affected under this paragraph shall at reasonable intervals be given an opportunity to demonstrate that the person can resume the competent practice of the regulated profession with reasonable skill and safety to the public. In any proceeding under this paragraph, neither the record of proceedings nor the orders entered by the board shall be used against a regulated person in any other proceeding.

(d) In addition to ordering a physical or mental examination, the board may, notwithstanding section 13.384 or 144.293, or any other law limiting access to medical or other health data, obtain medical data and health records relating to a licensee or applicant without the person's or applicant's consent if the board has probable cause to believe that a licensee is subject to paragraph (a), clause (10). The medical data may be requested from a provider as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a government agency, including the Department of Human Services and Direct Care and Treatment. A provider, insurance company, or government agency shall comply with any written request of the board under this section and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this section, unless the information is false and the provider giving the information knew, or had reason to know, the information was false. Information obtained under this section is private data on individuals as defined in section 13.02.

(e) If the board issues an order of immediate suspension of a license, a hearing must be held within 30 days of the suspension and completed without delay.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 26. Minnesota Statutes 2024, section 168.012, subdivision 1, is amended to read:

Subdivision 1. **Vehicles exempt from tax, fees, or plate display.** (a) The following vehicles are exempt from the provisions of this chapter requiring payment of tax and registration fees, except as provided in subdivision 1c:

(1) vehicles owned and used solely in the transaction of official business by the federal government, the state, or any political subdivision;

(2) vehicles owned and used exclusively by educational institutions and used solely in the transportation of pupils to and from those institutions;

(3) vehicles used solely in driver education programs at nonpublic high schools;

(4) vehicles owned by nonprofit charities and used exclusively to transport disabled persons for charitable, religious, or educational purposes;

(5) vehicles owned by nonprofit charities and used exclusively for disaster response and related activities;

(6) vehicles owned by ambulance services licensed under section 144E.10 that are equipped and specifically intended for emergency response or providing ambulance services; and

(7) vehicles owned by a commercial driving school licensed under section 171.34, or an employee of a commercial driving school licensed under section 171.34, and the vehicle is used exclusively for driver education and training.

(b) Provided the general appearance of the vehicle is unmistakable, the following vehicles are not required to register or display number plates:

(1) vehicles owned by the federal government;

(2) fire apparatuses, including fire-suppression support vehicles, owned or leased by the state or a political subdivision;

(3) police patrols owned or leased by the state or a political subdivision; and

(4) ambulances owned or leased by the state or a political subdivision.

(c) Unmarked vehicles used in general police work, liquor investigations, or arson investigations, and passenger automobiles, pickup trucks, and buses owned or operated by the Department of Corrections or by conservation officers of the Division of Enforcement and Field Service of the Department of Natural Resources, must be registered and must display appropriate license number plates, furnished by the registrar at cost. Original and renewal applications for these license plates authorized for use in general police work and for use by the Department of Corrections or by conservation officers must be accompanied by a certification signed by the appropriate chief of police if issued to a police vehicle, the appropriate sheriff if issued to a sheriff's vehicle, the commissioner of corrections if issued to a Department of Corrections vehicle, or the appropriate officer in charge if issued to a vehicle of any other law enforcement agency. The certification must be on a form prescribed by the commissioner and state that the vehicle will be used exclusively for a purpose authorized by this section.

(d) Unmarked vehicles used by the Departments of Revenue and Labor and Industry, fraud unit, in conducting seizures or criminal investigations must be registered and must display passenger vehicle classification license number plates, furnished at cost by the registrar. Original and renewal applications for these passenger vehicle license plates must be accompanied by a certification signed by the commissioner of revenue or the commissioner of labor and industry. The certification must be on a form prescribed by the commissioner and state that the vehicles will be used exclusively for the purposes authorized by this section.

(e) Unmarked vehicles used by the Division of Disease Prevention and Control of the Department of Health must be registered and must display passenger vehicle classification license number plates. These plates must be furnished at cost by the registrar. Original and renewal applications for these passenger vehicle license plates must be accompanied by a certification signed by the commissioner of health. The certification must be on a form prescribed by the commissioner and state that the vehicles will be used exclusively for the official duties of the Division of Disease Prevention and Control.

(f) Unmarked vehicles used by staff of the Gambling Control Board in gambling investigations and reviews must be registered and must display passenger vehicle classification license number plates. These plates must be furnished at cost by the registrar. Original and renewal applications for these passenger vehicle license plates must be accompanied by a certification signed by the board chair. The certification must be on a form prescribed by the commissioner and state that the vehicles will be used exclusively for the official duties of the Gambling Control Board.

(g) Unmarked vehicles used in general investigation, surveillance, supervision, and monitoring by ~~the Department of Human Services' Office of Special Investigations' staff; the Minnesota Sex Offender Program's executive director and the executive director's staff; and~~ the Office of Inspector General's staff, including, but not limited to, county fraud prevention investigators, must be registered and must display passenger vehicle classification license number plates, furnished by the registrar at cost. Original and renewal applications for passenger vehicle license plates must be accompanied by a certification signed by the commissioner of human services. The certification must be on a form prescribed by the commissioner and state that the vehicles must be used exclusively for the official duties of the Office of Special Investigations' staff~~; the Minnesota Sex Offender Program's executive director and the executive director's staff;~~ and the Office of the Inspector General's staff, including, but not limited to, contract and county fraud prevention investigators.

(h) Unmarked vehicles used in general investigation, surveillance, supervision, and monitoring by the Direct Care and Treatment Office of Special Investigations' staff and unmarked vehicles used by the Minnesota Sex Offender Program's executive director and the executive director's staff must be registered and must display passenger vehicle classification license number plates, furnished by the registrar at cost. Original and renewal applications for passenger vehicle license plates must be accompanied by a certification signed by the Direct Care and Treatment executive board. The certification must be on a form prescribed by the commissioner and state that the vehicles must be used exclusively for the official duties of the Minnesota Sex Offender Program's executive director and the executive director's staff, including but not limited to contract and county fraud prevention investigators.

~~(h)~~ (i) Each state hospital and institution for persons who are mentally ill and developmentally disabled may have one vehicle without the required identification on the sides of the vehicle. The vehicle must be registered and must display passenger vehicle classification license number plates. These plates must be furnished at cost by the registrar. Original and renewal applications for these passenger vehicle license plates must be accompanied by a certification signed by the hospital administrator. The certification must be on a form prescribed by the ~~commissioner~~ Direct Care and Treatment executive board and state that the vehicles will be used exclusively for the official duties of the state hospital or institution.

~~(i)~~ (j) Each county social service agency may have vehicles used for child and vulnerable adult protective services without the required identification on the sides of the vehicle. The vehicles must be registered and must display passenger vehicle classification license number plates. These plates must be furnished at cost by the registrar. Original and renewal applications for these passenger vehicle license plates must be accompanied by a certification signed by the agency administrator. The certification must be on a form prescribed by the commissioner and state that the vehicles will be used exclusively for the official duties of the social service agency.

~~(j)~~ (k) Unmarked vehicles used in general investigation, surveillance, supervision, and monitoring by tobacco inspector staff of the Department of Human Services' Alcohol and Drug Abuse Division for the purposes of tobacco inspections, investigations, and reviews must be registered and must display passenger vehicle classification license number plates, furnished at cost by the registrar. Original and renewal applications for passenger vehicle license plates must be accompanied by a certification signed by the commissioner of human services. The certification must be on a form prescribed by the commissioner and state that the vehicles will be used exclusively by tobacco inspector staff for the duties specified in this paragraph.

~~(k)~~ (l) All other motor vehicles must be registered and display tax-exempt number plates, furnished by the registrar at cost, except as provided in subdivision 1c. All vehicles required to display tax-exempt number plates must have the name of the state department or political subdivision, nonpublic high school operating a driver education program, licensed commercial driving school, or other qualifying organization or entity, plainly displayed on both sides of the vehicle. This identification must be in a color giving contrast with that of the part of the vehicle on which it is placed and must endure throughout the term of the registration. The identification must not be on a removable plate or placard and must be kept clean and visible at all times; except that a removable plate or placard may be utilized on vehicles leased or loaned to a political subdivision or to a nonpublic high school driver education program.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 27. Minnesota Statutes 2024, section 244.052, subdivision 4, is amended to read:

Subd. 4. **Law enforcement agency; disclosure of information to public.** (a) The law enforcement agency in the area where the predatory offender resides, expects to reside, is employed, or is regularly found, shall disclose to the public any information regarding the offender contained in the report forwarded to the agency under subdivision 3, paragraph (f), that is relevant and necessary to protect the public and to counteract the offender's dangerousness, consistent with the guidelines in paragraph (b). The extent of the information disclosed and the community to whom disclosure is made must relate to the level of danger posed by the offender, to the offender's pattern of offending behavior, and to the need of community members for information to enhance their individual and collective safety.

(b) The law enforcement agency shall employ the following guidelines in determining the scope of disclosure made under this subdivision:

(1) if the offender is assigned to risk level I, the agency may maintain information regarding the offender within the agency and may disclose it to other law enforcement agencies. Additionally, the agency may disclose the information to any victims of or witnesses to the offense committed by the offender. The agency shall disclose the information to victims of the offense committed by the offender who have requested disclosure and to adult members of the offender's immediate household;

(2) if the offender is assigned to risk level II, the agency also may disclose the information to agencies and groups that the offender is likely to encounter for the purpose of securing those institutions and protecting individuals in their care while they are on or near the premises of the institution. These agencies and groups include the staff members of public and private educational institutions, day care establishments, and establishments and organizations that primarily serve individuals likely to be victimized by the offender. The agency also may disclose the information to individuals the agency believes are likely to be victimized by the offender. The agency's belief shall be based on the offender's pattern of offending or victim preference as documented in the information provided by the Department of Corrections ~~or~~, the Department of Human Services, or Direct Care and Treatment. The agency may disclose the information to property assessors, property inspectors, code enforcement officials, and child protection officials who are likely to visit the offender's home in the course of their duties;

(3) if the offender is assigned to risk level III, the agency shall disclose the information to the persons and entities described in clauses (1) and (2) and to other members of the community whom the offender is likely to encounter, unless the law enforcement agency determines that public safety would be compromised by the disclosure or that a more limited disclosure is necessary to protect the identity of the victim.

Notwithstanding the assignment of a predatory offender to risk level II or III, a law enforcement agency may not make the disclosures permitted or required by clause (2) or (3), if: the offender is placed or resides in a residential facility. However, if an offender is placed or resides in a residential facility, the offender and the head of the facility shall designate the offender's likely residence upon release from the facility and the head of the facility shall notify the commissioner of corrections ~~or~~, the commissioner of human services, or the Direct Care and Treatment executive board of the offender's likely residence at least 14 days before the offender's scheduled release date. The commissioner shall give this information to the law enforcement agency having jurisdiction over the offender's likely residence. The head of the residential facility also shall notify the commissioner of corrections ~~or~~, the commissioner of human services, or the Direct Care and Treatment executive board within 48 hours after finalizing the offender's approved relocation plan to a permanent residence. Within five days after receiving this notification, the appropriate commissioner shall give to the appropriate law enforcement agency all relevant information the commissioner has concerning the offender, including information on the risk factors in the offender's history and the risk level to which the offender was assigned. After receiving this information, the law enforcement agency shall make the disclosures permitted or required by clause (2) or (3), as appropriate.

(c) As used in paragraph (b), clauses (2) and (3), "likely to encounter" means that:

(1) the organizations or community members are in a location or in close proximity to a location where the offender lives or is employed, or which the offender visits or is likely to visit on a regular basis, other than the location of the offender's outpatient treatment program; and

(2) the types of interaction which ordinarily occur at that location and other circumstances indicate that contact with the offender is reasonably certain.

(d) A law enforcement agency or official who discloses information under this subdivision shall make a good faith effort to make the notification within 14 days of receipt of a confirmed address from the Department of Corrections indicating that the offender will be, or has been, released from confinement, or accepted for supervision, or has moved to a new address and will reside at the address indicated. If a change occurs in the release plan, this notification provision does not require an extension of the release date.

(e) A law enforcement agency or official who discloses information under this subdivision shall not disclose the identity or any identifying characteristics of the victims of or witnesses to the offender's offenses.

(f) A law enforcement agency shall continue to disclose information on an offender as required by this subdivision for as long as the offender is required to register under section 243.166. This requirement on a law enforcement agency to continue to disclose information also applies to an offender who lacks a primary address and is registering under section 243.166, subdivision 3a.

(g) A law enforcement agency that is disclosing information on an offender assigned to risk level III to the public under this subdivision shall inform the commissioner of corrections what information is being disclosed and forward this information to the commissioner within two days of the agency's determination. The commissioner shall post this information on the Internet as required in subdivision 4b.

(h) A city council may adopt a policy that addresses when information disclosed under this subdivision must be presented in languages in addition to English. The policy may address when information must be presented orally, in writing, or both in additional languages by the law enforcement agency disclosing the information. The policy may provide for different approaches based on the prevalence of non-English languages in different neighborhoods.

(i) An offender who is the subject of a community notification meeting held pursuant to this section may not attend the meeting.

(j) When a school, day care facility, or other entity or program that primarily educates or serves children receives notice under paragraph (b), clause (3), that a level III predatory offender resides or works in the surrounding community, notice to parents must be made as provided in this paragraph. If the predatory offender identified in the notice is participating in programs offered by the facility that require or allow the person to interact with children other than the person's children, the principal or head of the entity must notify parents with children at the facility of the contents of the notice received pursuant to this section. The immunity provisions of subdivision 7 apply to persons disclosing information under this paragraph.

(k) When an offender for whom notification was made under this subdivision no longer resides, is employed, or is regularly found in the area, and the law enforcement agency that made the notification is aware of this, the agency shall inform the entities and individuals initially notified of the change in the offender's status. If notification was made under paragraph (b), clause (3), the agency shall provide the updated information required under this paragraph in a manner designed to ensure a similar scope of dissemination. However, the agency is not required to hold a public meeting to do so.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 28. Minnesota Statutes 2024, section 245.50, subdivision 2, is amended to read:

Subd. 2. **Purpose and authority.** (a) The purpose of this section is to enable appropriate treatment or detoxification services to be provided to individuals, across state lines from the individual's state of residence, in qualified facilities that are closer to the homes of individuals than are facilities available in the individual's home state.

(b) Unless prohibited by another law and subject to the exceptions listed in subdivision 3, a county board ~~or~~, the commissioner of human services, or the Direct Care and Treatment executive board may contract with an agency or facility in a bordering state for mental health, chemical health, or detoxification services for residents of Minnesota, and a Minnesota mental health, chemical health, or detoxification agency or facility may contract to provide services to residents of bordering states. Except as provided in subdivision 5, a person who receives services in another state under this section is subject to the laws of the state in which services are provided. A person who will receive services in another state under this section must be

informed of the consequences of receiving services in another state, including the implications of the differences in state laws, to the extent the individual will be subject to the laws of the receiving state.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 29. Minnesota Statutes 2024, section 245.52, is amended to read:

245.52 ~~COMMISSIONER OF HUMAN SERVICES~~ CHIEF EXECUTIVE OFFICER OF DIRECT CARE AND TREATMENT AS COMPACT ADMINISTRATOR.

The ~~commissioner of human services~~ chief executive officer of Direct Care and Treatment is hereby designated as "compact administrator." The ~~commissioner~~ chief executive officer shall have the powers and duties specified in the compact, and may, in the name of the state of Minnesota, subject to the approval of the attorney general as to form and legality, enter into such agreements authorized by the compact as the ~~commissioner~~ chief executive officer deems appropriate to effecting the purpose of the compact. The ~~commissioner~~ chief executive officer shall, within the limits of the appropriations for the care of persons with mental illness or developmental disabilities, authorize such payments as are necessary to discharge any financial obligations imposed upon this state by the compact or any agreement entered into under the compact.

If the patient has no established residence in a Minnesota county, the commissioner of human services shall designate the county of financial responsibility for the purposes of carrying out the provisions of the Interstate Compact on Mental Health as it pertains to patients being transferred to Minnesota. The commissioner of human services shall designate the county which is the residence of the person in Minnesota who initiates the earliest written request for the patient's transfer.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 30. Minnesota Statutes 2024, section 245.91, subdivision 2, is amended to read:

Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state Departments of Human Services, ~~Direct Care and Treatment,~~ Health, and Education~~,~~; of Direct Care and Treatment; and of local school districts and designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, developmental disability, substance use disorder, or emotional disturbance.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 31. Minnesota Statutes 2024, section 246.585, is amended to read:

246.585 CRISIS SERVICES.

Within the limits of appropriations, state-operated regional technical assistance must be available in each region to assist counties, Tribal Nations, residential and ~~day programming staff~~ vocational service providers, ~~and~~ families, and persons with disabilities to prevent or resolve crises that could lead to a ~~change in placement~~ person moving to a less integrated setting. ~~Crisis capacity must be provided on all regional treatment center campuses serving persons with developmental disabilities.~~ In addition, crisis capacity may be developed to serve 16 persons in the Twin Cities metropolitan area. ~~Technical assistance and consultation must also be available in each region to providers and counties.~~ Staff must be available to provide:

(1) individual assessments;

(2) program plan development and implementation assistance;

(3) analysis of service delivery problems; and

(4) assistance with transition planning, including technical assistance to counties, Tribal Nations, and service providers to develop new services, site the new services, and assist with community acceptance.

Sec. 32. Minnesota Statutes 2024, section 246C.06, subdivision 11, is amended to read:

Subd. 11. **Rulemaking.** (a) The executive board is authorized to adopt, amend, and repeal rules in accordance with chapter 14 to the extent necessary to implement this chapter or any responsibilities of Direct Care and Treatment specified in state law. The 18-month time limit under section 14.125 does not apply to the rulemaking authority under this subdivision.

(b) Until July 1, 2027, the executive board may adopt rules using the expedited rulemaking process in section 14.389.

(c) In accordance with section 15.039, all orders, rules, delegations, permits, and other privileges issued or granted by the Department of Human Services with respect to any function of Direct Care and Treatment and in effect at the time of the establishment of Direct Care and Treatment shall continue in effect as if such establishment had not occurred. The executive board may amend or repeal rules applicable to Direct Care and Treatment that were established by the Department of Human Services in accordance with chapter 14.

(d) The executive board must not adopt rules that go into effect or enforce rules prior to July 1, 2025.

EFFECTIVE DATE. This section is effective retroactively from July 1, 2024.

Sec. 33. Minnesota Statutes 2024, section 246C.12, subdivision 6, is amended to read:

Subd. 6. ~~**Dissemination of**~~ **Admission and stay criteria; dissemination.** (a) The executive board shall establish standard admission and continued-stay criteria for state-operated services facilities to ensure that appropriate services are provided in the least restrictive setting.

(b) The executive board shall periodically disseminate criteria for admission and continued stay in a state-operated services facility. The executive board shall disseminate the criteria to the courts of the state and counties.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 34. Minnesota Statutes 2024, section 246C.20, is amended to read:

246C.20 CONTRACT WITH DEPARTMENT OF HUMAN SERVICES FOR ADMINISTRATIVE SERVICES.

(a) Direct Care and Treatment shall contract with the Department of Human Services to provide determinations on issues of county of financial responsibility under chapter 256G and to provide administrative and judicial review of direct care and treatment matters according to section 256.045.

(b) The executive board may prescribe rules necessary to carry out this ~~subdivision~~ section, except that the executive board must not create any rule purporting to control the decision making or processes of state human services judges under section 256.045, subdivision 4, or the decision making or processes of the commissioner of human services issuing an advisory opinion or recommended order to the executive board under section 256G.09, subdivision 3. The executive board must not create any rule purporting to control

processes for determinations of financial responsibility under chapter 256G or administrative and judicial review under section 256.045 on matters outside of the jurisdiction of Direct Care and Treatment.

(c) The executive board and commissioner of human services may adopt joint rules necessary to accomplish the purposes of this section.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 35. **[246C.21] INTERVIEW EXPENSES.**

Job applicants for professional, administrative, or highly technical positions recruited by the Direct Care and Treatment executive board may be reimbursed for necessary travel expenses to and from interviews arranged by the Direct Care and Treatment executive board.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 36. **[246C.211] FEDERAL GRANTS FOR MINNESOTA INDIANS.**

The Direct Care and Treatment executive board is authorized to enter into contracts with the United States Departments of Health and Human Services; Education; and Interior, Bureau of Indian Affairs, for the purposes of receiving federal grants for the welfare and relief of Minnesota Indians.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 37. Minnesota Statutes 2024, section 252.291, subdivision 3, is amended to read:

Subd. 3. **Duties of commissioner of human services.** The commissioner shall:

(1) establish ~~standard admission criteria for state hospitals and~~ county utilization targets to limit and reduce the number of intermediate care beds in state hospitals and community facilities in accordance with approved waivers under United States Code, title 42, sections 1396 to 1396p, as amended through December 31, 1987, to ~~assure~~ ensure that appropriate services are provided in the least restrictive setting;

(2) define services, including respite care, that may be needed in meeting individual service plan objectives;

(3) provide technical assistance so that county boards may establish a request for proposal system for meeting individual service plan objectives through home and community-based services; alternative community services; or, if no other alternative will meet the needs of identifiable individuals for whom the county is financially responsible, a new intermediate care facility for persons with developmental disabilities;

(4) establish a client tracking and evaluation system as required under applicable federal waiver regulations, Code of Federal Regulations, title 42, sections 431, 435, 440, and 441, as amended through December 31, 1987; and

(5) develop a state plan for the delivery and funding of residential day and support services to persons with developmental disabilities in Minnesota. The biennial developmental disability plan shall include but not be limited to:

(i) county by county maximum intermediate care bed utilization quotas;

(ii) plans for the development of the number and types of services alternative to intermediate care beds;

(iii) procedures for the administration and management of the plan;

(iv) procedures for the evaluation of the implementation of the plan; and

(v) the number, type, and location of intermediate care beds targeted for decertification.

The commissioner shall modify the plan to ensure conformance with the medical assistance home and community-based services waiver.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 38. Minnesota Statutes 2024, section 252.50, subdivision 5, is amended to read:

Subd. 5. **Location of programs.** (a) In determining the location of state-operated, community-based programs, the needs of the individual client shall be paramount. The executive board shall also take into account:

(1) prioritization of ~~beds~~ services in state-operated, community-based programs for individuals with complex behavioral needs that cannot be met by private community-based providers;

(2) choices made by individuals who chose to move to a more integrated setting, and shall coordinate with the lead agency to ensure that appropriate person-centered transition plans are created;

(3) the personal preferences of the persons being served and their families as determined by Minnesota Rules, parts 9525.0004 to 9525.0036;

(4) the location of the support services established by the individual service plans of the persons being served;

(5) the appropriate grouping of the persons served;

(6) the availability of qualified staff;

(7) the need for state-operated, community-based programs in the geographical region of the state; and

(8) a reasonable commuting distance from a regional treatment center or the residences of the program staff.

(b) The executive board must locate state-operated, community-based programs in coordination with the commissioner of human services according to section 252.28.

Sec. 39. Minnesota Statutes 2024, section 253B.07, subdivision 2b, is amended to read:

Subd. 2b. **Apprehend and hold orders.** (a) The court may order the treatment facility or state-operated treatment program to hold the proposed patient or direct a health officer, peace officer, or other person to take the proposed patient into custody and transport the proposed patient to a treatment facility or state-operated treatment program for observation, evaluation, diagnosis, care, treatment, and, if necessary, confinement, when:

(1) there has been a particularized showing by the petitioner that serious physical harm to the proposed patient or others is likely unless the proposed patient is immediately apprehended;

(2) the proposed patient has not voluntarily appeared for the examination or the commitment hearing pursuant to the summons; or

(3) a person is held pursuant to section 253B.051 and a request for a petition for commitment has been filed.

(b) The order of the court may be executed on any day and at any time by the use of all necessary means including the imposition of necessary restraint upon the proposed patient. Where possible, a peace officer taking the proposed patient into custody pursuant to this subdivision shall not be in uniform and shall not use a vehicle visibly marked as a law enforcement vehicle. Except as provided in section 253D.10, subdivision 2, in the case of an individual on a judicial hold due to a petition for civil commitment under chapter 253D, assignment of custody during the hold is to the ~~commissioner~~ executive board. The ~~commissioner~~ executive board is responsible for determining the appropriate placement within a secure treatment facility under the authority of the ~~commissioner~~ executive board.

(c) A proposed patient must not be allowed or required to consent to nor participate in a clinical drug trial while an order is in effect under this subdivision. A consent given while an order is in effect is void and unenforceable. This paragraph does not prohibit a patient from continuing participation in a clinical drug trial if the patient was participating in the clinical drug trial at the time the order was issued under this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 40. Minnesota Statutes 2024, section 253B.09, subdivision 3a, is amended to read:

Subd. 3a. **Reporting judicial commitments; private treatment program or facility.** Notwithstanding section 253B.23, subdivision 9, when a court commits a patient to a non-state-operated treatment facility or program, the court shall report the commitment to the ~~commissioner~~ executive board through the supreme court information system for purposes of providing commitment information for firearm background checks under section 246C.15. If the patient is committed to a state-operated treatment program, the court shall send a copy of the commitment order to ~~the commissioner and~~ the executive board.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 41. Minnesota Statutes 2024, section 253B.10, subdivision 1, is amended to read:

Subdivision 1. **Administrative requirements.** (a) When a person is committed, the court shall issue a warrant or an order committing the patient to the custody of the head of the treatment facility, state-operated treatment program, or community-based treatment program. The warrant or order shall state that the patient meets the statutory criteria for civil commitment.

(b) The executive board shall prioritize civilly committed patients being admitted from jail or a correctional institution or who are referred to a state-operated treatment facility for competency attainment or a competency examination under sections 611.40 to 611.59 for admission to a medically appropriate state-operated direct care and treatment bed based on the decisions of physicians in the executive medical director's office, using a priority admissions framework. The framework must account for a range of factors for priority admission, including but not limited to:

(1) the length of time the person has been on a waiting list for admission to a state-operated direct care and treatment program since the date of the order under paragraph (a), or the date of an order issued under sections 611.40 to 611.59;

(2) the intensity of the treatment the person needs, based on medical acuity;

(3) the person's revoked provisional discharge status;

(4) the person's safety and safety of others in the person's current environment;

(5) whether the person has access to necessary or court-ordered treatment;

(6) distinct and articulable negative impacts of an admission delay on the facility referring the individual for treatment; and

(7) any relevant federal prioritization requirements.

Patients described in this paragraph must be admitted to a state-operated treatment program within ~~48 hours~~ the timelines specified in section 253B.1005. The commitment must be ordered by the court as provided in section 253B.09, subdivision 1, paragraph (d). Patients committed to a secure treatment facility or less restrictive setting as ordered by the court under section 253B.18, subdivisions 1 and 2, must be prioritized for admission to a state-operated treatment program using the priority admissions framework in this paragraph.

(c) Upon the arrival of a patient at the designated treatment facility, state-operated treatment program, or community-based treatment program, the head of the facility or program shall retain the duplicate of the warrant and endorse receipt upon the original warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must be filed in the court of commitment. After arrival, the patient shall be under the control and custody of the head of the facility or program.

(d) Copies of the petition for commitment, the court's findings of fact and conclusions of law, the court order committing the patient, the report of the court examiners, and the prepetition report, and any medical and behavioral information available shall be provided at the time of admission of a patient to the designated treatment facility or program to which the patient is committed. Upon a patient's referral to the executive board for admission pursuant to subdivision 1, paragraph (b), any inpatient hospital, treatment facility, jail, or correctional facility that has provided care or supervision to the patient in the previous two years shall, when requested by the treatment facility or executive board, provide copies of the patient's medical and behavioral records to the executive board for purposes of preadmission planning. This information shall be provided by the head of the treatment facility to treatment facility staff in a consistent and timely manner and pursuant to all applicable laws.

(e) ~~Patients described in paragraph (b) must be admitted to a state-operated treatment program within 48 hours of the Office of Executive Medical Director, under section 246C.09, or a designee determining that a medically appropriate bed is available. This paragraph expires on June 30, 2025.~~

~~(f)~~ Within four business days of determining which state-operated direct care and treatment program or programs are appropriate for an individual, the executive medical director's office or a designee must notify the source of the referral and the responsible county human services agency, the individual being ordered to direct care and treatment, and the district court that issued the order of the determination. The notice shall include which program or programs are appropriate for the person's priority status. Any interested person may provide additional information or request updated priority status about the individual to the executive medical director's office or a designee while the individual is awaiting admission. Updated Priority status of an individual will only be disclosed to interested persons who are legally authorized to receive private information about the individual. When an available bed has been identified, the executive medical director's office or a designee must notify the designated agency and the facility where the individual is awaiting admission that the individual has been accepted for admission to a particular state-operated direct care and treatment program and the earliest possible date the admission can occur. The designated agency or facility

where the individual is awaiting admission must transport the individual to the admitting state-operated direct care and treatment program no more than 48 hours after the offered admission date.

Sec. 42. **[253B.1005] ADMISSION TIMELINES.**

Subdivision 1. **Admission required within 48 hours.** Unless required otherwise under this section, patients described in section 253B.10, subdivision 1, paragraph (b), must be admitted to a state-operated treatment program within 48 hours.

Subd. 2. **Temporary alternative admission timeline.** Patients described in section 253B.10, subdivision 1, paragraph (b), must be admitted to a state-operated treatment program within 48 hours of the Office of Executive Medical Director, under section 246C.09, or a designee determining that a medically appropriate bed is available. This subdivision expires on June 30, 2027.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 43. Minnesota Statutes 2024, section 253B.141, subdivision 2, is amended to read:

Subd. 2. **Apprehension; return to facility or program.** (a) Upon receiving the report of absence from the head of the treatment facility, state-operated treatment program, or community-based treatment program or the committing court, a patient may be apprehended and held by a peace officer in any jurisdiction pending return to the facility or program from which the patient is absent without authorization. A patient may also be returned to any state-operated treatment program or any other treatment facility or community-based treatment program willing to accept the person. A person who has a mental illness and is dangerous to the public and detained under this subdivision may be held in a jail or lockup only if:

(1) there is no other feasible place of detention for the patient;

(2) the detention is for less than 24 hours; and

(3) there are protections in place, including segregation of the patient, to ensure the safety of the patient.

(b) If a patient is detained under this subdivision, the head of the facility or program from which the patient is absent shall arrange to pick up the patient within 24 hours of the time detention was begun and shall be responsible for securing transportation for the patient to the facility or program. The expense of detaining and transporting a patient shall be the responsibility of the facility or program from which the patient is absent. The expense of detaining and transporting a patient to a state-operated treatment program shall be paid by the ~~commissioner~~ executive board unless paid by the patient or persons on behalf of the patient.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 44. Minnesota Statutes 2024, section 253B.18, subdivision 6, is amended to read:

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

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

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

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

(3) the need for continued institutionalization;

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

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

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

(d) If the committed person is not returned to the original, nonsecure transfer facility within 60 days of being readmitted to a secure treatment facility, the transfer is revoked and the committed person must remain in a secure treatment facility. The committed person must immediately be notified in writing of the revocation.

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

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

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

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

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

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

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

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

(k) A committed person aggrieved by a transfer revocation decision may petition the special review board within seven business days after receipt of the revocation report for a review of the revocation. The matter must be scheduled within 30 days. The special review board shall review the circumstances leading

to the revocation and, after considering the factors in paragraph (b), shall recommend to the ~~commissioner~~ executive board whether or not the revocation shall be upheld. The special review board may also recommend a new transfer out of a secure treatment facility at the time of the revocation hearing.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 45. Minnesota Statutes 2024, section 253B.19, subdivision 2, is amended to read:

Subd. 2. **Petition; hearing.** (a) A patient committed as a person who has a mental illness and is dangerous to the public under section 253B.18, or the county attorney of the county from which the patient was committed or the county of financial responsibility, may petition the judicial appeal panel for a rehearing and reconsideration of a decision by the ~~commissioner~~ executive board under section 253B.18, subdivision 5. The judicial appeal panel must not consider petitions for relief other than those considered by the executive board from which the appeal is taken. The petition must be filed with the supreme court within 30 days after the decision of the executive board is signed. The hearing must be held within 45 days of the filing of the petition unless an extension is granted for good cause.

(b) For an appeal under paragraph (a), the supreme court shall refer the petition to the chief judge of the judicial appeal panel. The chief judge shall notify the patient, the county attorney of the county of commitment, the designated agency, the executive board, the head of the facility or program to which the patient was committed, any interested person, and other persons the chief judge designates, of the time and place of the hearing on the petition. The notice shall be given at least 14 days prior to the date of the hearing.

(c) Any person may oppose the petition. The patient, the patient's counsel, the county attorney of the committing county or the county of financial responsibility, and the executive board shall participate as parties to the proceeding pending before the judicial appeal panel and shall, except when the patient is committed solely as a person who has a mental illness and is dangerous to the public, no later than 20 days before the hearing on the petition, inform the judicial appeal panel and the opposing party in writing whether they support or oppose the petition and provide a summary of facts in support of their position. The judicial appeal panel may appoint court examiners and may adjourn the hearing from time to time. It shall hear and receive all relevant testimony and evidence and make a record of all proceedings. The patient, the patient's counsel, and the county attorney of the committing county or the county of financial responsibility have the right to be present and may present and cross-examine all witnesses and offer a factual and legal basis in support of their positions. The petitioning party seeking discharge or provisional discharge bears the burden of going forward with the evidence, which means presenting a prima facie case with competent evidence to show that the person is entitled to the requested relief. If the petitioning party has met this burden, the party opposing discharge or provisional discharge bears the burden of proof by clear and convincing evidence that the discharge or provisional discharge should be denied. A party seeking transfer under section 253B.18, subdivision 6, must establish by a preponderance of the evidence that the transfer is appropriate.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 46. Minnesota Statutes 2024, section 253D.29, subdivision 1, is amended to read:

Subdivision 1. **Factors.** (a) A person who is committed as a sexually dangerous person or a person with a sexual psychopathic personality shall not be transferred out of a secure treatment facility unless the transfer is appropriate. Transfer may be to ~~other treatment programs~~ a facility under the control of the executive board.

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

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

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

(3) the need for continued institutionalization;

(4) which ~~other treatment program~~ facility can best meet the person's needs; and

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

Sec. 47. Minnesota Statutes 2024, section 253D.29, subdivision 2, is amended to read:

Subd. 2. **Voluntary readmission to a secure treatment facility.** (a) After a committed person has been transferred out of a secure treatment facility pursuant to subdivision 1 and with the consent of the executive director, a committed person may voluntarily return to a secure treatment facility for a period of up to 60 days.

(b) If the committed person is not returned to the ~~other treatment program~~ secure treatment facility to which the person was originally transferred pursuant to subdivision 1 within 60 days of being readmitted to a secure treatment facility under this subdivision, the transfer to the ~~other treatment program~~ secure treatment facility under subdivision 1 is revoked and the committed person shall remain in a secure treatment facility. The committed person shall immediately be notified in writing of the revocation.

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

(d) If the transfer has not been revoked and the committed person is to be returned to the ~~other treatment program~~ facility to which the committed person was originally transferred pursuant to subdivision 1 with no substantive change to the conditions of the transfer ordered pursuant to subdivision 1, no action by the special review board or judicial appeal panel is required.

Sec. 48. Minnesota Statutes 2024, section 253D.29, subdivision 3, is amended to read:

Subd. 3. **Revocation.** (a) The executive director may revoke a transfer made pursuant to subdivision 1 and require a committed person to return to a secure treatment facility if:

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

(2) the committed person has regressed in clinical progress so that the ~~other treatment program~~ facility to which the committed person was transferred is no longer sufficient to meet the committed person's needs.

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

(c) The committed person must be provided a copy of the revocation report and informed, orally and in writing, of the rights of a committed person under this section. The revocation report shall be served upon

the committed person and the committed person's counsel. The report shall outline the specific reasons for the revocation including, but not limited to, the specific facts upon which the revocation is based.

(d) If a committed person's transfer is revoked, the committed person may re-petition for transfer according to section 253D.27.

(e) Any committed person aggrieved by a transfer revocation decision may petition the special review board within seven days, exclusive of Saturdays, Sundays, and legal holidays, after receipt of the revocation report for a review of the revocation. The matter shall be scheduled within 30 days. The special review board shall review the circumstances leading to the revocation and, after considering the factors in subdivision 1, paragraph (b), shall recommend to the judicial appeal panel whether or not the revocation shall be upheld. The special review board may also recommend a new transfer out of a secure treatment facility at the time of the revocation hearing.

Sec. 49. Minnesota Statutes 2024, section 253D.30, subdivision 4, is amended to read:

Subd. 4. **Voluntary readmission.** (a) With the consent of the executive director, a committed person may voluntarily return to ~~the Minnesota Sex Offender Program~~ a secure treatment facility from provisional discharge for a period of up to 60 days.

(b) If the committed person is not returned to provisional discharge status within 60 days of being readmitted to ~~the Minnesota Sex Offender Program~~ a secure treatment facility, the provisional discharge is revoked. The committed person shall immediately be notified of the revocation in writing. Within 15 days of receiving notice of the revocation, the committed person may request a review of the matter before the special review board. The special review board shall review the circumstances of the revocation and, after applying the standards in subdivision 5, paragraph (a), shall recommend to the judicial appeal panel whether or not the revocation shall be upheld. The board may recommend a return to provisional discharge status.

(c) If the provisional discharge has not been revoked and the committed person is to be returned to provisional discharge, ~~the Minnesota Sex Offender Program is not required to petition for a further review by the special review board~~ no action by the special review board or judicial appeal panel is required unless the committed person's return to the community results in substantive change to the existing provisional discharge plan.

Sec. 50. Minnesota Statutes 2024, section 253D.30, subdivision 5, is amended to read:

Subd. 5. **Revocation.** (a) The executive director may revoke a provisional discharge if either of the following grounds exist:

(1) the committed person has departed from the conditions of the provisional discharge plan; or

(2) the committed person is exhibiting behavior which may be dangerous to self or others.

(b) The executive director may revoke the provisional discharge and, either orally or in writing, order that the committed person be immediately returned to a secure treatment facility ~~or other treatment program~~. A report documenting reasons for revocation shall be issued by the executive director within seven days after the committed person is returned to the secure treatment facility ~~or other treatment program~~. Advance notice to the committed person of the revocation is not required.

(c) The committed person must be provided a copy of the revocation report and informed, orally and in writing, of the rights of a committed person under this section. The revocation report shall be served upon

the committed person, the committed person's counsel, and the county attorneys of the county of commitment and the county of financial responsibility. The report shall outline the specific reasons for the revocation, including but not limited to the specific facts upon which the revocation is based.

(d) An individual who is revoked from provisional discharge must successfully re-petition the special review board and judicial appeal panel prior to being placed back on provisional discharge.

Sec. 51. Minnesota Statutes 2024, 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 (bb):

(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.

(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.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 52. Minnesota Statutes 2024, section 256.01, subdivision 5, is amended to read:

Subd. 5. **Gifts, contributions, pensions and benefits; acceptance.** The commissioner may receive and accept on behalf of patients ~~and residents at the several state hospitals for persons with mental illness or developmental disabilities during the period of their hospitalization and while on provisional discharge therefrom,~~ money due and payable to them as old age and survivors insurance benefits, veterans benefits, pensions or other such monetary benefits. Such gifts, contributions, pensions and benefits shall be deposited in and disbursed from the social welfare fund provided for in sections 256.88 to 256.92.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 53. Minnesota Statutes 2024, section 256.019, subdivision 1, is amended to read:

Subdivision 1. **Retention rates.** When an assistance recovery amount is collected and posted by a county agency under the provisions governing public assistance programs including general assistance medical care formerly codified in chapter 256D, general assistance, and Minnesota supplemental aid, the county may keep one-half of the recovery made by the county agency using any method other than recoupment. For medical assistance, if the recovery is made by a county agency using any method other than recoupment, the county may keep one-half of the nonfederal share of the recovery. For MinnesotaCare, if the recovery is collected and posted by the county agency, the county may keep one-half of the nonfederal share of the recovery.

This does not apply to recoveries from medical providers or to recoveries begun by the Department of Human Services' Surveillance and Utilization Review Division~~, State Hospital Collections Unit,~~ and ~~the~~ Benefit Recoveries Division ~~or~~, ~~by~~ the Direct Care and Treatment State Hospital Collections Unit, the attorney general's office, or child support collections.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 54. Minnesota Statutes 2024, section 256.0281, is amended to read:

256.0281 INTERAGENCY DATA EXCHANGE.

(a) The Department of Human Services, the Department of Health, Direct Care and Treatment, and the Office of the Ombudsman for Mental Health and Developmental Disabilities may establish interagency agreements governing the electronic exchange of data on providers and individuals collected, maintained, or used by each agency when such exchange is outlined by each agency in an interagency agreement to accomplish the purposes in clauses (1) to (4):

(1) to improve provider enrollment processes for home and community-based services and state plan home care services;

(2) to improve quality management of providers between state agencies;

(3) to establish and maintain provider eligibility to participate as providers under Minnesota health care programs; or

(4) to meet the quality assurance reporting requirements under federal law under section 1915(c) of the Social Security Act related to home and community-based waiver programs.

(b) Each interagency agreement must include provisions to ensure anonymity of individuals, including mandated reporters, and must outline the specific uses of and access to shared data within each agency. Electronic interfaces between source data systems developed under these interagency agreements must incorporate these provisions as well as other HIPAA provisions related to individual data.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 55. Minnesota Statutes 2024, section 256.0451, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) The requirements in this section apply to all fair hearings and appeals under sections 142A.20, subdivision 2, and 256.045, subdivision 3, paragraph (a), clauses (1), (2), (3), (5), (6),

(7), (10), and (12). Except as provided in subdivisions 3 and 19, the requirements under this section apply to fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (4), (8), (9), and (11).

(b) For purposes of this section, "person" means an individual who, on behalf of themselves or their household, is appealing or disputing or challenging an action, a decision, or a failure to act, by an agency ~~in the human services system~~ subject to this section. When a person involved in a proceeding under this section is represented by an attorney or by an authorized representative, the term "person" also means the person's attorney or authorized representative. Any notice sent to the person involved in the hearing must also be sent to the person's attorney or authorized representative.

(c) For purposes of this section, "agency" means ~~the~~ a county human services agency, ~~the~~ a state ~~human services~~ agency, and, where applicable, any entity involved under a contract, subcontract, grant, or subgrant with the state agency or with a county agency, that provides or operates programs or services in which appeals are governed by section 256.045.

(d) For purposes of this section, "state agency" means the Department of Human Services; the Department of Health; the Department of Education; the Department of Children, Youth, and Families; or Direct Care and Treatment.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 56. Minnesota Statutes 2024, section 256.0451, subdivision 3, is amended to read:

Subd. 3. **Agency appeal summary.** (a) Except in fair hearings and appeals under section 256.045, subdivision 3, paragraph (a), clauses (4), (9), and (10), the agency involved in an appeal must prepare a state agency appeal summary for each fair hearing appeal. The state agency appeal summary shall be mailed or otherwise delivered to the person who is involved in the appeal at least three working days before the date of the hearing. The state agency appeal summary must also be mailed or otherwise delivered to the ~~department's~~ Department of Human Services' Appeals Office at least three working days before the date of the fair hearing appeal.

(b) In addition, the human services judge shall confirm that the state agency appeal summary is mailed or otherwise delivered to the person involved in the appeal as required under paragraph (a). The person involved in the fair hearing should be provided, through the state agency appeal summary or other reasonable methods, appropriate information about the procedures for the fair hearing and an adequate opportunity to prepare. These requirements apply equally to the state agency or an entity under contract when involved in the appeal.

(c) The contents of the state agency appeal summary must be adequate to inform the person involved in the appeal of the evidence on which the agency relies and the legal basis for the agency's action or determination.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 57. Minnesota Statutes 2024, section 256.0451, subdivision 6, is amended to read:

Subd. 6. **Appeal request for emergency assistance or urgent matter.** (a) When an appeal involves an application for emergency assistance, the agency involved shall mail or otherwise deliver the state agency appeal summary to the ~~department's~~ Department of Human Services' Appeals Office within two working days of receiving the request for an appeal. A person may also request that a fair hearing be held on an

emergency basis when the issue requires an immediate resolution. The human services judge shall schedule the fair hearing on the earliest available date according to the urgency of the issue involved. Issuance of the recommended decision after an emergency hearing shall be expedited.

(b) The applicable commissioner or executive board shall issue a written decision within five working days of receiving the recommended decision, shall immediately inform the parties of the outcome by telephone, and shall mail the decision no later than two working days following the date of the decision.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 58. Minnesota Statutes 2024, section 256.0451, subdivision 8, is amended to read:

Subd. 8. **Subpoenas.** A person involved in a fair hearing or the agency may request a subpoena for a witness, for evidence, or for both. A reasonable number of subpoenas shall be issued to require the attendance and the testimony of witnesses, and the production of evidence relating to any issue of fact in the appeal hearing. The request for a subpoena must show a need for the subpoena and the general relevance to the issues involved. The subpoena shall be issued in the name of the Department of Human Services and shall be served and enforced as provided in section 357.22 and the Minnesota Rules of Civil Procedure.

An individual or entity served with a subpoena may petition the human services judge in writing to vacate or modify a subpoena. The human services judge shall resolve such a petition in a prehearing conference involving all parties and shall make a written decision. A subpoena may be vacated or modified if the human services judge determines that the testimony or evidence sought does not relate with reasonable directness to the issues of the fair hearing appeal; that the subpoena is unreasonable, over broad, or oppressive; that the evidence sought is repetitious or cumulative; or that the subpoena has not been served reasonably in advance of the time when the appeal hearing will be held.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 59. Minnesota Statutes 2024, section 256.0451, subdivision 9, is amended to read:

Subd. 9. **No ex parte contact.** The human services judge shall not have ex parte contact on substantive issues with the agency or with any person or witness in a fair hearing appeal. No employee of ~~the Department or~~ an agency shall review, interfere with, change, or attempt to influence the recommended decision of the human services judge in any fair hearing appeal, except through the procedure allowed in subdivision 18. The limitations in this subdivision do not affect the applicable commissioner's or executive board's authority to review or reconsider decisions or make final decisions.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 60. Minnesota Statutes 2024, section 256.0451, subdivision 18, is amended to read:

Subd. 18. **Inviting comment by ~~department~~ state agency.** The human services judge or the applicable commissioner or executive board may determine that a written comment by the ~~department~~ state agency about the policy implications of a specific legal issue could help resolve a pending appeal. Such a written policy comment from the ~~department~~ state agency shall be obtained only by a written request that is also sent to the person involved and to the agency or its representative. When such a written comment is received, both the person involved in the hearing and the agency shall have adequate opportunity to review, evaluate, and respond to the written comment, including submission of additional testimony or evidence, and cross-examination concerning the written comment.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 61. Minnesota Statutes 2024, section 256.0451, subdivision 22, is amended to read:

Subd. 22. **Decisions.** A timely, written decision must be issued in every appeal. Each decision must contain a clear ruling on the issues presented in the appeal hearing and should contain a ruling only on questions directly presented by the appeal and the arguments raised in the appeal.

(a) A written decision must be issued within 90 days of the date the person involved requested the appeal unless a shorter time is required by law. An additional 30 days is provided in those cases where the applicable commissioner or executive board refuses to accept the recommended decision. In appeals of maltreatment determinations or disqualifications filed pursuant to section 256.045, subdivision 3, paragraph (a), clause (4), (8), or (9), that also give rise to possible licensing actions, the 90-day period for issuing final decisions does not begin until the later of the date that the licensing authority provides notice to the appeals division that the authority has made the final determination in the matter or the date the appellant files the last appeal in the consolidated matters.

(b) The decision must contain both findings of fact and conclusions of law, clearly separated and identified. The findings of fact must be based on the entire record. Each finding of fact made by the human services judge shall be supported by a preponderance of the evidence unless a different standard is required under the regulations of a particular program. The "preponderance of the evidence" means, in light of the record as a whole, the evidence leads the human services judge to believe that the finding of fact is more likely to be true than not true. The legal claims or arguments of a participant do not constitute either a finding of fact or a conclusion of law, except to the extent the human services judge adopts an argument as a finding of fact or conclusion of law.

The decision shall contain at least the following:

(1) a listing of the date and place of the hearing and the participants at the hearing;

(2) a clear and precise statement of the issues, including the dispute under consideration and the specific points which must be resolved in order to decide the case;

(3) a listing of the material, including exhibits, records, reports, placed into evidence at the hearing, and upon which the hearing decision is based;

(4) the findings of fact based upon the entire hearing record. The findings of fact must be adequate to inform the participants and any interested person in the public of the basis of the decision. If the evidence is in conflict on an issue which must be resolved, the findings of fact must state the reasoning used in resolving the conflict;

(5) conclusions of law that address the legal authority for the hearing and the ruling, and which give appropriate attention to the claims of the participants to the hearing;

(6) a clear and precise statement of the decision made resolving the dispute under consideration in the hearing; and

(7) written notice of the right to appeal to district court or to request reconsideration, and of the actions required and the time limits for taking appropriate action to appeal to district court or to request a reconsideration.

(c) The human services judge shall not independently investigate facts or otherwise rely on information not presented at the hearing. The human services judge may not contact other agency personnel, except as provided in subdivision 18. The human services judge's recommended decision must be based exclusively on the testimony and evidence presented at the hearing, and legal arguments presented, and the human services judge's research and knowledge of the law.

(d) The applicable commissioner ~~will~~ or executive board must review the recommended decision and accept or refuse to accept the decision according to section 142A.20, subdivision 3, or 256.045, subdivision 5 or 5a.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 62. Minnesota Statutes 2024, section 256.0451, subdivision 23, is amended to read:

Subd. 23. **Refusal to accept recommended orders.** (a) If the applicable commissioner or executive board refuses to accept the recommended order from the human services judge, the person involved, the person's attorney or authorized representative, and the agency shall be sent a copy of the recommended order, a detailed explanation of the basis for refusing to accept the recommended order, and the proposed modified order.

(b) The person involved and the agency shall have at least ten business days to respond to the proposed modification of the recommended order. The person involved and the agency may submit a legal argument concerning the proposed modification, and may propose to submit additional evidence that relates to the proposed modified order.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 63. Minnesota Statutes 2024, section 256.0451, subdivision 24, is amended to read:

Subd. 24. **Reconsideration.** (a) Reconsideration may be requested within 30 days of the date of the applicable commissioner's or executive board's final order. If reconsideration is requested under section 142A.20, subdivision 3, or 256.045, subdivision 5 or 5a, the other participants in the appeal shall be informed of the request. The person seeking reconsideration has the burden to demonstrate why the matter should be reconsidered. The request for reconsideration may include legal argument and may include proposed additional evidence supporting the request. The other participants shall be sent a copy of all material submitted in support of the request for reconsideration and must be given ten days to respond.

(b) When the requesting party raises a question as to the appropriateness of the findings of fact, the applicable commissioner or executive board shall review the entire record.

(c) When the requesting party questions the appropriateness of a conclusion of law, the applicable commissioner or executive board shall consider the recommended decision, the decision under reconsideration, and the material submitted in connection with the reconsideration. The applicable commissioner or executive board shall review the remaining record as necessary to issue a reconsidered decision.

(d) The applicable commissioner or executive board shall issue a written decision on reconsideration in a timely fashion. The decision must clearly inform the parties that this constitutes the final administrative decision, advise the participants of the right to seek judicial review, and the deadline for doing so.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 64. Minnesota Statutes 2024, section 256.4825, is amended to read:

256.4825 REPORT REGARDING PROGRAMS AND SERVICES FOR PEOPLE WITH DISABILITIES.

The Minnesota State Council on Disability, the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota may submit an annual report by January 15 of each year, beginning in 2012, to the chairs and ranking minority members of the legislative committees with jurisdiction over programs serving people with disabilities as provided in this section. The report must describe the existing state policies and goals for programs serving people with disabilities including, but not limited to, programs for employment, transportation, housing, education, quality assurance, consumer direction, physical and programmatic access, and health. The report must provide data and measurements to assess the extent to which the policies and goals are being met. The commissioner of human services, the Direct Care and Treatment executive board, and the commissioners of other state agencies administering programs for people with disabilities shall cooperate with the Minnesota State Council on Disability, the Minnesota Consortium for Citizens with Disabilities, and the Arc of Minnesota and provide those organizations with existing published information and reports that will assist in the preparation of the report.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 65. Minnesota Statutes 2024, section 256.93, subdivision 1, is amended to read:

Subdivision 1. **Limitations.** In any case where the guardianship of any child with a developmental disability or who is disabled, dependent, neglected or delinquent, or a child born to a mother who was not married to the child's father when the child was conceived nor when the child was born, has been ~~committed~~ appointed to the commissioner of human services, and in any case where the guardianship of any person with a developmental disability has been ~~committed~~ appointed to the commissioner of human services, the court having jurisdiction of the estate may on such notice as the court may direct, authorize the commissioner to take possession of the personal property in the estate, liquidate it, and hold the proceeds in trust for the ward, to be invested, expended and accounted for as provided by sections 256.88 to 256.92.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 66. Minnesota Statutes 2024, section 256.98, subdivision 7, is amended to read:

Subd. 7. **Division of recovered amounts.** Except for recoveries under chapter 142E, if the state is responsible for the recovery, the amounts recovered shall be paid to the appropriate units of government. If the recovery is directly attributable to a county, the county may retain one-half of the nonfederal share of any recovery from a recipient or the recipient's estate.

This subdivision does not apply to recoveries from medical providers or to recoveries involving the Department of Human ~~services,~~ Services' Surveillance and Utilization Review Division~~, state hospital collections unit,~~ and ~~the~~ Benefit Recoveries Division or the Direct Care and Treatment State Hospital Collections Unit.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 67. Minnesota Statutes 2024, section 256B.092, subdivision 10, is amended to read:

Subd. 10. **Admission of persons to and discharge of persons from regional treatment centers.** (a) Prior to the admission of a person to a regional treatment center program for persons with developmental

disabilities, the case manager shall make efforts to secure community-based alternatives. If these alternatives are rejected by the person, the person's legal guardian or conservator, or the county agency in favor of a regional treatment center placement, the case manager shall document the reasons why the alternatives were rejected.

(b) Assessment and support planning must be completed in accordance with requirements identified in section 256B.0911.

(c) No discharge shall take place until disputes are resolved under section 256.045, subdivision 4a, or until a review by the ~~commissioner~~ Direct Care and Treatment executive board is completed upon request of the chief executive officer or program director of the regional treatment center, or the county agency. For persons under public guardianship, the ombudsman may request a review or hearing under section 256.045.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 68. Minnesota Statutes 2024, section 256G.09, subdivision 4, is amended to read:

Subd. 4. **Appeals.** A local agency that is aggrieved by the order of ~~the~~ a department or the executive board may appeal the opinion to the district court of the county responsible for furnishing assistance or services by serving a written copy of a notice of appeal on ~~the~~ a commissioner or the executive board and any adverse party of record within 30 days after the date the department issued the opinion, and by filing the original notice and proof of service with the court administrator of district court. Service may be made personally or by mail. Service by mail is complete upon mailing.

~~The~~ A commissioner or the executive board may elect to become a party to the proceedings in district court. The court may consider the matter in or out of chambers and shall take no new or additional evidence.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 69. Minnesota Statutes 2024, section 256G.09, subdivision 5, is amended to read:

Subd. 5. **Payment pending appeal.** After ~~the~~ a department or the executive board issues an opinion in any submission under this section, the service or assistance covered by the submission must be provided or paid pending or during an appeal to the district court.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 70. Minnesota Statutes 2024, section 299F.77, subdivision 2, is amended to read:

Subd. 2. **Background check.** (a) For licenses issued by the commissioner under section 299F.73, the applicant for licensure must provide the commissioner with all of the information required by Code of Federal Regulations, title 28, section 25.7. The commissioner shall forward the information to the superintendent of the Bureau of Criminal Apprehension so that criminal records, histories, and warrant information on the applicant can be retrieved from the Minnesota Crime Information System and the National Instant Criminal Background Check System, as well as the civil commitment records maintained by ~~the Department of Human Services~~ Direct Care and Treatment. The results must be returned to the commissioner to determine if the individual applicant is qualified to receive a license.

(b) For permits issued by a county sheriff or chief of police under section 299F.75, the applicant for a permit must provide the county sheriff or chief of police with all of the information required by Code of Federal Regulations, title 28, section 25.7. The county sheriff or chief of police must check, by means of

electronic data transfer, criminal records, histories, and warrant information on each applicant through the Minnesota Crime Information System and the National Instant Criminal Background Check System, as well as the civil commitment records maintained by ~~the Department of Human Services~~ Direct Care and Treatment. The county sheriff or chief of police shall use the results of the query to determine if the individual applicant is qualified to receive a permit.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 71. Minnesota Statutes 2024, section 342.04, is amended to read:

342.04 STUDIES; REPORTS.

(a) The office shall conduct a study to determine the expected size and growth of the regulated cannabis industry and hemp consumer industry, including an estimate of the demand for cannabis flower and cannabis products, the number and geographic distribution of cannabis businesses needed to meet that demand, and the anticipated business from residents of other states.

(b) The office shall conduct a study to determine the size of the illicit cannabis market, the sources of illicit cannabis flower and illicit cannabis products in the state, the locations of citations issued and arrests made for cannabis offenses, and the subareas, such as census tracts or neighborhoods, that experience a disproportionately large amount of cannabis enforcement.

(c) The office shall conduct a study on impaired driving to determine:

(1) the number of accidents involving one or more drivers who admitted to using cannabis flower, cannabis products, lower-potency hemp edibles, or hemp-derived consumer products, or who tested positive for cannabis or tetrahydrocannabinol;

(2) the number of arrests of individuals for impaired driving in which the individual tested positive for cannabis or tetrahydrocannabinol; and

(3) the number of convictions for driving under the influence of cannabis flower, cannabis products, lower-potency hemp edibles, hemp-derived consumer products, or tetrahydrocannabinol.

(d) The office shall provide preliminary reports on the studies conducted pursuant to paragraphs (a) to (c) to the legislature by January 15, 2024, and shall provide final reports to the legislature by January 15, 2025. The reports may be consolidated into a single report by the office.

(e) The office shall collect existing data from the Department of Human Services, Department of Health, Direct Care and Treatment, Minnesota state courts, and hospitals licensed under chapter 144 on the utilization of mental health and substance use disorder services, emergency room visits, and commitments to identify any increase in the services provided or any increase in the number of visits or commitments. The office shall also obtain summary data from existing first episode psychosis programs on the number of persons served by the programs and number of persons on the waiting list. All information collected by the office under this paragraph shall be included in the report required under paragraph (f).

(f) The office shall conduct an annual market analysis on the status of the regulated cannabis industry and submit a report of the findings. The office shall submit the report by January 15, 2025, and each January 15 thereafter and the report may be combined with the annual report submitted by the office. The process of completing the market analysis must include holding public meetings to solicit the input of consumers, market stakeholders, and potential new applicants and must include an assessment as to whether the office has issued the necessary number of licenses in order to:

(1) ensure the sufficient supply of cannabis flower and cannabis products to meet demand;

(2) provide market stability;

(3) ensure a competitive market; and

(4) limit the sale of unregulated cannabis flower and cannabis products.

(g) The office shall submit an annual report to the legislature by January 15, 2024, and each January 15 thereafter. The annual report shall include but not be limited to the following:

(1) the status of the regulated cannabis industry;

(2) the status of the illicit cannabis market and hemp consumer industry;

(3) the number of accidents, arrests, and convictions involving drivers who admitted to using cannabis flower, cannabis products, lower-potency hemp edibles, or hemp-derived consumer products or who tested positive for cannabis or tetrahydrocannabinol;

(4) the change in potency, if any, of cannabis flower and cannabis products available through the regulated market;

(5) progress on providing opportunities to individuals and communities that experienced a disproportionate, negative impact from cannabis prohibition, including but not limited to providing relief from criminal convictions and increasing economic opportunities;

(6) the status of racial and geographic diversity in the cannabis industry;

(7) proposed legislative changes, including but not limited to recommendations to streamline licensing systems and related administrative processes;

(8) information on the adverse effects of second-hand smoke from any cannabis flower, cannabis products, and hemp-derived consumer products that are consumed by the combustion or vaporization of the product and the inhalation of smoke, aerosol, or vapor from the product; and

(9) recommendations for the levels of funding for:

(i) a coordinated education program to address and raise public awareness about the top three adverse health effects, as determined by the commissioner of health, associated with the use of cannabis flower, cannabis products, lower-potency hemp edibles, or hemp-derived consumer products by individuals under 21 years of age;

(ii) a coordinated education program to educate pregnant individuals, breastfeeding individuals, and individuals who may become pregnant on the adverse health effects of cannabis flower, cannabis products, lower-potency hemp edibles, and hemp-derived consumer products;

(iii) training, technical assistance, and educational materials for home visiting programs, Tribal home visiting programs, and child welfare workers regarding safe and unsafe use of cannabis flower, cannabis products, lower-potency hemp edibles, and hemp-derived consumer products in homes with infants and young children;

(iv) model programs to educate middle school and high school students on the health effects on children and adolescents of the use of cannabis flower, cannabis products, lower-potency hemp edibles, hemp-derived consumer products, and other intoxicating or controlled substances;

(v) grants issued through the CanTrain, CanNavigate, CanStartup, and CanGrow programs;

(vi) grants to organizations for community development in social equity communities through the CanRenew program;

(vii) training of peace officers and law enforcement agencies on changes to laws involving cannabis flower, cannabis products, lower-potency hemp edibles, and hemp-derived consumer products and the law's impact on searches and seizures;

(viii) training of peace officers to increase the number of drug recognition experts;

(ix) training of peace officers on the cultural uses of sage and distinguishing use of sage from the use of cannabis flower, including whether the Board of Peace Officer Standards and Training should approve or develop training materials;

(x) the retirement and replacement of drug detection canines; and

(xi) the Department of Human Services and county social service agencies to address any increase in demand for services.

(g) In developing the recommended funding levels under paragraph (f), clause (9), items (vii) to (xi), the office shall consult with local law enforcement agencies, the Minnesota Chiefs of Police Association, the Minnesota Sheriff's Association, the League of Minnesota Cities, the Association of Minnesota Counties, and county social services agencies.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 72. Minnesota Statutes 2024, section 352.91, subdivision 3f, is amended to read:

Subd. 3f. **Additional Direct Care and Treatment personnel.** (a) "Covered correctional service" means service by a state employee in one of the employment positions specified in paragraph (b) in the state-operated forensic services program or the Minnesota Sex Offender Program if at least 75 percent of the employee's working time is spent in direct contact with patients and the determination of this direct contact is certified to the executive director by the ~~commissioner of human services or~~ Direct Care and Treatment executive board.

(b) The employment positions are:

(1) baker;

(2) behavior analyst 2;

(3) behavior analyst 3;

(4) certified occupational therapy assistant 1;

(5) certified occupational therapy assistant 2;

(6) client advocate;

(7) clinical program therapist 2;

(8) clinical program therapist 3;

(9) clinical program therapist 4;

(10) cook;

(11) culinary supervisor;

(12) customer services specialist principal;

(13) dental assistant registered;

(14) dental hygienist;

(15) food service worker;

(16) food services supervisor;

(17) group supervisor;

(18) group supervisor assistant;

(19) human services support specialist;

(20) licensed alcohol and drug counselor;

(21) licensed practical nurse;

(22) management analyst 3;

(23) music therapist;

(24) occupational therapist;

(25) occupational therapist, senior;

(26) physical therapist;

(27) psychologist 1;

(28) psychologist 2;

(29) psychologist 3;

(30) recreation program assistant;

(31) recreation therapist lead;

(32) recreation therapist senior;

(33) rehabilitation counselor senior;

(34) residential program lead;

(35) security supervisor;

(36) skills development specialist;

(37) social worker senior;

(38) social worker specialist;

(39) social worker specialist, senior;

(40) special education program assistant;

(41) speech pathology clinician;

(42) substance use disorder counselor senior;

(43) work therapy assistant; and

(44) work therapy program coordinator.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 73. Minnesota Statutes 2024, section 401.17, subdivision 1, is amended to read:

Subdivision 1. **Establishment; members.** (a) The commissioner must establish a Community Supervision Advisory Committee to develop and make recommendations to the commissioner on standards for probation, supervised release, and community supervision. The committee consists of 19 members as follows:

(1) two directors appointed by the Minnesota Association of Community Corrections Act Counties;

(2) two probation directors appointed by the Minnesota Association of County Probation Officers;

(3) three county commissioner representatives appointed by the Association of Minnesota Counties;

(4) two behavioral health, treatment, or programming providers who work directly with individuals on correctional supervision, one appointed by the ~~Department of Human Services~~ Department of Corrections and one appointed by the Minnesota Association of County Social Service Administrators;

(5) two representatives appointed by the Minnesota Indian Affairs Council;

(6) two commissioner-appointed representatives from the Department of Corrections;

(7) the chair of the statewide Evidence-Based Practice Advisory Committee;

(8) three individuals who have been supervised, either individually or collectively, under each of the state's three community supervision delivery systems appointed by the commissioner in consultation with the Minnesota Association of County Probation Officers and the Minnesota Association of Community Corrections Act Counties;

(9) an advocate for victims of crime appointed by the commissioner; and

(10) a representative from a community-based research and advocacy entity appointed by the commissioner.

(b) When an appointing authority selects an individual for membership on the committee, the authority must make reasonable efforts to reflect geographic diversity and to appoint qualified members of protected groups, as defined under section 43A.02, subdivision 33.

(c) Chapter 15 applies to the extent consistent with this section.

(d) The commissioner must convene the first meeting of the committee on or before October 1, 2023.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 74. Minnesota Statutes 2024, section 507.071, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For the purposes of this section the following terms have the meanings given:

(a) "Beneficiary" or "grantee beneficiary" means a person or entity named as a grantee beneficiary in a transfer on death deed, including a successor grantee beneficiary.

(b) "County agency" means the county department or office designated to recover medical assistance benefits from the estates of decedents.

(c) "Grantor owner" means an owner, whether individually, as a joint tenant, or as a tenant in common, named as a grantor in a transfer on death deed upon whose death the conveyance or transfer of the described real property is conditioned. Grantor owner does not include a spouse who joins in a transfer on death deed solely for the purpose of conveying or releasing statutory or other marital interests in the real property to be conveyed or transferred by the transfer on death deed.

(d) "Owner" means a person having an ownership or other interest in all or part of the real property to be conveyed or transferred by a transfer on death deed either at the time the deed is executed or at the time the transfer becomes effective. Owner does not include a spouse who joins in a transfer on death deed solely for the purpose of conveying or releasing statutory or other marital interests in the real property to be conveyed or transferred by the transfer on death deed.

(e) "Property" and "interest in real property" mean any interest in real property located in this state which is transferable on the death of the owner and includes, without limitation, an interest in real property defined in chapter 500, a mortgage, a deed of trust, a security interest in, or a security pledge of, an interest in real property, including the rights to payments of the indebtedness secured by the security instrument, a judgment, a tax lien, both the seller's and purchaser's interest in a contract for deed, land contract, purchase agreement, or earnest money contract for the sale and purchase of real property, including the rights to payments under such contracts, or any other lien on, or interest in, real property.

(f) "Recorded" means recorded in the office of the county recorder or registrar of titles, as appropriate for the real property described in the instrument to be recorded.

(g) "State agency" means the Department of Human Services or any successor agency or Direct Care and Treatment or any successor agency.

(h) "Transfer on death deed" means a deed authorized under this section.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 75. Minnesota Statutes 2024, section 611.46, subdivision 1, is amended to read:

Subdivision 1. **Order to competency attainment program.** (a) If the court finds the defendant incompetent and the charges have not been dismissed, the court shall order the defendant to participate in a program to assist the defendant in attaining competency. The court may order participation in a competency attainment program provided outside of a jail, a jail-based competency attainment program, or an alternative program. The court must determine the least-restrictive program appropriate to meet the defendant's needs and public safety. In making this determination, the court must consult with the forensic navigator and consider any recommendations of the court examiner. The court shall not order a defendant to participate in a jail-based program or a state-operated treatment program if the highest criminal charge is a targeted misdemeanor.

(b) If the court orders the defendant to a locked treatment facility or jail-based program, the court must calculate the defendant's custody credit and cannot order the defendant to a locked treatment facility or jail-based program for a period that would cause the defendant's custody credit to exceed the maximum sentence for the underlying charge.

(c) The court may only order the defendant to participate in competency attainment at an inpatient or residential treatment program under this section if the head of the treatment program determines that admission to the program is clinically appropriate and consents to the defendant's admission. The court may only order the defendant to participate in competency attainment at a state-operated treatment facility under this section if the Direct Care and Treatment executive board or a designee determines that admission of the defendant is clinically appropriate and consents to the defendant's admission. The court may require a competency program that qualifies as a locked facility or a state-operated treatment program to notify the court in writing of the basis for refusing consent for admission of the defendant in order to ensure transparency and maintain an accurate record. The court may not require personal appearance of any representative of a competency program. The court shall send a written request for notification to the locked facility or state-operated treatment program and the locked facility or state-operated treatment program shall provide a written response to the court within ten days of receipt of the court's request.

(d) If the defendant is confined in jail and has not received competency attainment services within 30 days of the finding of incompetency, the court shall review the case with input from the prosecutor and defense counsel and may:

(1) order the defendant to participate in an appropriate competency attainment program that takes place outside of a jail;

(2) order a conditional release of the defendant with conditions that include but are not limited to a requirement that the defendant participate in a competency attainment program when one becomes available and accessible;

(3) make a determination as to whether the defendant is likely to attain competency in the reasonably foreseeable future and proceed under section 611.49; or

(4) upon a motion, dismiss the charges in the interest of justice.

(e) The court may order any hospital, treatment facility, or correctional facility that has provided care or supervision to a defendant in the previous two years to provide copies of the defendant's medical records to the competency attainment program or alternative program in which the defendant was ordered to participate. This information shall be provided in a consistent and timely manner and pursuant to all applicable laws.

(f) If at any time the defendant refuses to participate in a competency attainment program or an alternative program, the head of the program shall notify the court and any entity responsible for supervision of the defendant.

(g) At any time, the head of the program may discharge the defendant from the program or facility. The head of the program must notify the court, prosecutor, defense counsel, and any entity responsible for the supervision of the defendant prior to any planned discharge. Absent emergency circumstances, this notification shall be made five days prior to the discharge if the defendant is not being discharged to jail or a correctional facility. Upon the receipt of notification of discharge or upon the request of either party in response to notification of discharge, the court may order that a defendant who is subject to bail or unmet conditions of release be returned to jail upon being discharged from the program or facility. If the court orders a defendant

returned to jail, the court shall notify the parties and head of the program at least one day before the defendant's planned discharge, except in the event of an emergency discharge where one day notice is not possible. The court must hold a review hearing within seven days of the defendant's return to jail. The forensic navigator must be given notice of the hearing and be allowed to participate.

(h) If the defendant is discharged from the program or facility under emergency circumstances, notification of emergency discharge shall include a description of the emergency circumstances and may include a request for emergency transportation. The court shall make a determination on a request for emergency transportation within 24 hours. Nothing in this section prohibits a law enforcement agency from transporting a defendant pursuant to any other authority.

(i) If the defendant is ordered to participate in an inpatient or residential competency attainment or alternative program, the program or facility must notify the court, prosecutor, defense counsel, forensic navigator, and any entity responsible for the supervision of the defendant if the defendant is placed on a leave or elopement status from the program and if the defendant returns to the program from a leave or elopement status.

(j) Defense counsel, prosecutors, and forensic navigators must have access to information relevant to a defendant's participation and treatment in a competency attainment program or alternative program, including but not limited to discharge planning.

Sec. 76. Minnesota Statutes 2024, section 611.55, is amended by adding a subdivision to read:

Subd. 5. **Data access.** Forensic navigators must have access to all data collected, created, or maintained by a competency attainment program or an alternative program regarding a defendant in order for navigators to carry out their duties under this section. A competency attainment program or alternative program may request a copy of the court order appointing the forensic navigator before disclosing any private information about a defendant.

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

Sec. 77. Minnesota Statutes 2024, section 611.57, subdivision 2, is amended to read:

Subd. 2. **Membership.** (a) The Certification Advisory Committee consists of the following members:

(1) a mental health professional, as defined in section 245I.02, subdivision 27, with community behavioral health experience, appointed by the governor;

(2) a board-certified forensic psychiatrist with experience in competency evaluations, providing competency attainment services, or both, appointed by the governor;

(3) a board-certified forensic psychologist with experience in competency evaluations, providing competency attainment services, or both, appointed by the governor;

(4) the president of the Minnesota Corrections Association or a designee;

(5) the Direct Care and Treatment ~~deputy commissioner~~ chief executive officer or a designee;

(6) the president of the Minnesota Association of County Social Service Administrators or a designee;

(7) the president of the Minnesota Association of Community Mental Health Providers or a designee;

(8) the president of the Minnesota Sheriffs' Association or a designee; and

(9) the executive director of the National Alliance on Mental Illness Minnesota or a designee.

(b) Members of the advisory committee serve without compensation and at the pleasure of the appointing authority. Vacancies shall be filled by the appointing authority consistent with the qualifications of the vacating member required by this subdivision.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 78. Minnesota Statutes 2024, section 611.57, subdivision 4, is amended to read:

Subd. 4. **Duties.** The Certification Advisory Committee shall consult with the Department of Human Services, the Department of Health, ~~and~~ the Department of Corrections, and Direct Care and Treatment; make recommendations to the Minnesota Competency Attainment Board regarding competency attainment curriculum, certification requirements for competency attainment programs including jail-based programs, and certification of individuals to provide competency attainment services; and provide information and recommendations on other issues relevant to competency attainment as requested by the board.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 79. Minnesota Statutes 2024, section 624.7131, subdivision 1, is amended to read:

Subdivision 1. **Information.** Any person may apply for a transferee permit by providing the following information in writing to the chief of police of an organized full time police department of the municipality in which the person resides or to the county sheriff if there is no such local chief of police:

(1) the name, residence, telephone number, and driver's license number or nonqualification certificate number, if any, of the proposed transferee;

(2) the sex, date of birth, height, weight, and color of eyes, and distinguishing physical characteristics, if any, of the proposed transferee;

(3) a statement that the proposed transferee authorizes the release to the local police authority of commitment information about the proposed transferee maintained by the ~~commissioner of human services~~ Direct Care and Treatment executive board, to the extent that the information relates to the proposed transferee's eligibility to possess a pistol or semiautomatic military-style assault weapon under section 624.713, subdivision 1; and

(4) a statement by the proposed transferee that the proposed transferee is not prohibited by section 624.713 from possessing a pistol or semiautomatic military-style assault weapon.

The statements shall be signed and dated by the person applying for a permit. At the time of application, the local police authority shall provide the applicant with a dated receipt for the application. The statement under clause (3) must comply with any applicable requirements of Code of Federal Regulations, title 42, sections 2.31 to 2.35, with respect to consent to disclosure of alcohol or drug abuse patient records.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 80. Minnesota Statutes 2024, section 624.7131, subdivision 2, is amended to read:

Subd. 2. **Investigation.** The chief of police or sheriff shall check criminal histories, records and warrant information relating to the applicant through the Minnesota Crime Information System, the national criminal record repository, and the National Instant Criminal Background Check System. The chief of police or

sheriff shall also make a reasonable effort to check other available state and local record-keeping systems. The chief of police or sheriff shall obtain commitment information from the ~~commissioner of human services~~ Direct Care and Treatment executive board as provided in section 246C.15.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 81. Minnesota Statutes 2024, section 624.7132, subdivision 1, is amended to read:

Subdivision 1. **Required information.** Except as provided in this section and section 624.7131, every person who agrees to transfer a pistol or semiautomatic military-style assault weapon shall report the following information in writing to the chief of police of the organized full-time police department of the municipality where the proposed transferee resides or to the appropriate county sheriff if there is no such local chief of police:

(1) the name, residence, telephone number, and driver's license number or nonqualification certificate number, if any, of the proposed transferee;

(2) the sex, date of birth, height, weight, and color of eyes, and distinguishing physical characteristics, if any, of the proposed transferee;

(3) a statement that the proposed transferee authorizes the release to the local police authority of commitment information about the proposed transferee maintained by the ~~commissioner of human services~~ Direct Care and Treatment executive board, to the extent that the information relates to the proposed transferee's eligibility to possess a pistol or semiautomatic military-style assault weapon under section 624.713, subdivision 1;

(4) a statement by the proposed transferee that the transferee is not prohibited by section 624.713 from possessing a pistol or semiautomatic military-style assault weapon; and

(5) the address of the place of business of the transferor.

The report shall be signed and dated by the transferor and the proposed transferee. The report shall be delivered by the transferor to the chief of police or sheriff no later than three days after the date of the agreement to transfer, excluding weekends and legal holidays. The statement under clause (3) must comply with any applicable requirements of Code of Federal Regulations, title 42, sections 2.31 to 2.35, with respect to consent to disclosure of alcohol or drug abuse patient records.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 82. Minnesota Statutes 2024, section 624.7132, subdivision 2, is amended to read:

Subd. 2. **Investigation.** Upon receipt of a transfer report, the chief of police or sheriff shall check criminal histories, records and warrant information relating to the proposed transferee through the Minnesota Crime Information System, the national criminal record repository, and the National Instant Criminal Background Check System. The chief of police or sheriff shall also make a reasonable effort to check other available state and local record-keeping systems. The chief of police or sheriff shall obtain commitment information from the ~~commissioner of human services~~ Direct Care and Treatment executive board as provided in section 246C.15.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 83. Minnesota Statutes 2024, section 624.714, subdivision 3, is amended to read:

Subd. 3. **Form and contents of application.** (a) Applications for permits to carry must be an official, standardized application form, adopted under section 624.7151, and must set forth in writing only the following information:

(1) the applicant's name, residence, telephone number, if any, and driver's license number or state identification card number;

(2) the applicant's sex, date of birth, height, weight, and color of eyes and hair, and distinguishing physical characteristics, if any;

(3) the township or statutory city or home rule charter city, and county, of all Minnesota residences of the applicant in the last five years, though not including specific addresses;

(4) the township or city, county, and state of all non-Minnesota residences of the applicant in the last five years, though not including specific addresses;

(5) a statement that the applicant authorizes the release to the sheriff of commitment information about the applicant maintained by the ~~commissioner of human services~~ Direct Care and Treatment executive board or any similar agency or department of another state where the applicant has resided, to the extent that the information relates to the applicant's eligibility to possess a firearm; and

(6) a statement by the applicant that, to the best of the applicant's knowledge and belief, the applicant is not prohibited by law from possessing a firearm.

(b) The statement under paragraph (a), clause (5), must comply with any applicable requirements of Code of Federal Regulations, title 42, sections 2.31 to 2.35, with respect to consent to disclosure of alcohol or drug abuse patient records.

(c) An applicant must submit to the sheriff an application packet consisting only of the following items:

(1) a completed application form, signed and dated by the applicant;

(2) an accurate photocopy of the certificate described in subdivision 2a, paragraph (c), that is submitted as the applicant's evidence of training in the safe use of a pistol; and

(3) an accurate photocopy of the applicant's current driver's license, state identification card, or the photo page of the applicant's passport.

(d) In addition to the other application materials, a person who is otherwise ineligible for a permit due to a criminal conviction but who has obtained a pardon or expungement setting aside the conviction, sealing the conviction, or otherwise restoring applicable rights, must submit a copy of the relevant order.

(e) Applications must be submitted in person.

(f) The sheriff may charge a new application processing fee in an amount not to exceed the actual and reasonable direct cost of processing the application or $100, whichever is less. Of this amount, $10 must be submitted to the commissioner and deposited into the general fund.

(g) This subdivision prescribes the complete and exclusive set of items an applicant is required to submit in order to apply for a new or renewal permit to carry. The applicant must not be asked or required to submit, voluntarily or involuntarily, any information, fees, or documentation beyond that specifically required by

this subdivision. This paragraph does not apply to alternate training evidence accepted by the sheriff under subdivision 2a, paragraph (d).

(h) Forms for new and renewal applications must be available at all sheriffs' offices and the commissioner must make the forms available on the Internet.

(i) Application forms must clearly display a notice that a permit, if granted, is void and must be immediately returned to the sheriff if the permit holder is or becomes prohibited by law from possessing a firearm. The notice must list the applicable state criminal offenses and civil categories that prohibit a person from possessing a firearm.

(j) Upon receipt of an application packet and any required fee, the sheriff must provide a signed receipt indicating the date of submission.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 84. Minnesota Statutes 2024, section 624.714, subdivision 4, is amended to read:

Subd. 4. **Investigation.** (a) The sheriff must check, by means of electronic data transfer, criminal records, histories, and warrant information on each applicant through the Minnesota Crime Information System and the National Instant Criminal Background Check System. The sheriff shall also make a reasonable effort to check other available and relevant federal, state, or local record-keeping systems. The sheriff must obtain commitment information from the ~~commissioner of human services~~ Direct Care and Treatment executive board as provided in section 246C.15 or, if the information is reasonably available, as provided by a similar statute from another state.

(b) When an application for a permit is filed under this section, the sheriff must notify the chief of police, if any, of the municipality where the applicant resides. The police chief may provide the sheriff with any information relevant to the issuance of the permit.

(c) The sheriff must conduct a background check by means of electronic data transfer on a permit holder through the Minnesota Crime Information System and the National Instant Criminal Background Check System at least yearly to ensure continuing eligibility. The sheriff may also conduct additional background checks by means of electronic data transfer on a permit holder at any time during the period that a permit is in effect.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 85. Minnesota Statutes 2024, section 631.40, subdivision 3, is amended to read:

Subd. 3. **Direct Care and Treatment and Departments of Human Services; Children, Youth, and Families; and Health licensees.** When a person who is affiliated with a program or facility governed or licensed by Direct Care and Treatment; the Department of Human Services~~,~~; the Department of Children, Youth, and Families~~,~~; or the Department of Health is convicted of a disqualifying crime, the probation officer or corrections agent shall notify the commissioner of the conviction, as provided in chapter 245C.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 86. **REVISOR INSTRUCTION.**

(a) The revisor of statutes shall renumber Minnesota Statutes, section 252.50, subdivision 5, as Minnesota Statutes, section 246C.11, subdivision 4a.

(b) The revisor of statutes shall renumber Minnesota Statutes, section 252.52, as Minnesota Statutes, section 246C.191.

(c) The revisor of statutes shall make necessary cross-reference changes consistent with the renumbering in this section.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 87. **REPEALER.**

(a) Minnesota Statutes 2024, sections 245.4862; 246.015, subdivision 3; 246.50, subdivision 2; and 246B.04, subdivision 1a, are repealed.

(b) Laws 2024, chapter 79, article 1, sections 15; 16; and 17, are repealed.

EFFECTIVE DATE. This section is effective July 1, 2025.

ARTICLE 4

BEHAVIORAL HEALTH

Section 1. Minnesota Statutes 2024, section 3.757, subdivision 1, is amended to read:

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

(b) "Municipality" has the meaning provided in section 466.01, subdivision 1.

(c) "Opioid litigation" means any civil litigation, demand, or settlement in lieu of litigation alleging unlawful conduct related to the marketing, sale, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids.

(d) "Released claim" means any cause of action or other claim that has been released in a statewide opioid settlement agreement, including matters identified as a released claim as that term or a comparable term is defined in a statewide opioid settlement agreement.

(e) "Settling defendant" means an entity that engages in, has engaged in, or has provided consultation services regarding the manufacture, marketing, promotion, sale, distribution, or dispensing of opioids, and that has been the subject of a statewide opioid settlement agreement or bankruptcy plan, including but not limited to Johnson & Johnson, AmerisourceBergen Corporation, Cardinal Health, Inc., McKesson Corporation, Teva Pharmaceuticals, Allergan plc, CVS Health Corporation, Walgreens Boots Alliance, Inc., ~~and~~ Walmart, Inc., and Purdue Pharma L.P., as well as related subsidiaries, affiliates, officers, directors, and other related entities specifically named as a released entity in a statewide opioid settlement agreement.

(f) "Statewide opioid settlement agreement" means an agreement~~, including consent judgments, assurances of discontinuance, and related agreements or documents,~~ between the attorney general, on behalf of the state, and a settling defendant, to provide or allocate remuneration for conduct related to the manufacture, marketing, promotion, sale, dispensing, or distribution of opioids in this state or other alleged illegal actions that contributed to the excessive use of opioids. A statewide opioid settlement agreement includes consent judgments, assurances of discontinuance, and related agreements or documents, that contain structural or payment provisions requiring or anticipating the participation of municipalities and allowing for the allocation of settlement funds between the state and municipalities to be set through a state-specific agreement.

Sec. 2. Minnesota Statutes 2024, section 4.046, subdivision 2, is amended to read:

Subd. 2. **Subcabinet membership.** The subcabinet consists of the following members:

(1) the commissioner of human services;

(2) the commissioner of health;

(3) the commissioner of education;

(4) the commissioner of public safety;

(5) the commissioner of corrections;

(6) the commissioner of management and budget;

(7) the commissioner of higher education;

(8) the commissioner of children, youth, and families;

(9) the chief executive officer of direct care and treatment;

(10) the commissioner of commerce;

(11) the director of the Office of Cannabis Management;

~~(8)~~ (12) the chair of the Interagency Council on Homelessness; and

~~(9)~~ (13) the governor's director of addiction and recovery, who shall serve as chair of the subcabinet.

Sec. 3. Minnesota Statutes 2024, section 4.046, subdivision 3, is amended to read:

Subd. 3. **Policy and strategy development.** The subcabinet must engage in the following duties related to the development of opioid use, substance use, and addiction policy and strategy:

(1) identify challenges and opportunities that exist relating to accessing treatment and support services and develop recommendations to overcome these barriers for all Minnesotans;

(2) with input from affected communities, develop policies and strategies that will reduce barriers and gaps in service for all Minnesotans seeking treatment for opioid or substance use disorder, particularly for those Minnesotans who are members of communities disproportionately impacted by substance use and addiction;

(3) develop policies and strategies that the state may adopt to expand Minnesota's recovery infrastructure, including detoxification or withdrawal management facilities, treatment facilities, and sober housing;

(4) identify innovative services and strategies for effective treatment and support;

(5) develop policies and strategies to expand services and support for people in Minnesota suffering from opioid or substance use disorder through partnership with the Opioid Epidemic Response Advisory Council and other relevant partnerships;

(6) develop policies and strategies for agencies to manage addiction and the relationship it has with co-occurring conditions;

(7) identify policies and strategies to address opioid or substance use disorder among Minnesotans experiencing homelessness; ~~and~~

(8) submit recommendations to the legislature addressing opioid use, substance use, and addiction in Minnesota~~.~~; and

(9) develop and publish a comprehensive substance use and addiction plan for the state. The plan must establish goals and priorities for a comprehensive continuum of care for substance misuse and substance use disorder for Minnesota. All state agencies' operating programs related to substance use prevention, harm reduction, treatment, or recovery or that are administering state or federal funds for those programs shall set program goals and priorities in accordance with the state plan. Each state agency shall submit its relevant plans and budgets to the subcabinet for review upon request.

Sec. 4. Minnesota Statutes 2024, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a minor who is admitted to a residential program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules, parts 9530.6510 to 9530.6590. For purposes of all subdivisions except subdivisions 20, 28, 29, 32, and 33, "resident" also means a person who is admitted to a facility licensed to provide intensive residential treatment services or residential crisis stabilization under section 245I.23.

Sec. 5. Minnesota Statutes 2024, section 169A.284, is amended to read:

169A.284 ~~CHEMICAL DEPENDENCY~~ COMPREHENSIVE ASSESSMENT CHARGE; SURCHARGE.

Subdivision 1. **When required.** (a) When a court sentences a person convicted of an offense enumerated in section 169A.70, subdivision 2 (~~chemical use~~ substance use disorder assessment; requirement; form), except as provided in paragraph (c), it shall order the person to pay the cost of the substance use disorder assessment directly to the entity conducting the assessment or providing the assessment services in an amount determined by the entity conducting or providing the service and shall impose a ~~chemical dependency~~ substance use disorder assessment charge of $25. The court may waive the $25 substance use disorder assessment charge, but may not waive the cost for the assessment paid directly to the entity conducting the assessment or providing assessment services. A person shall pay an additional surcharge of $5 if the person is convicted of a violation of section 169A.20 (driving while impaired) within five years of a prior impaired driving conviction or a prior conviction for an offense arising out of an arrest for a violation of section 169A.20 or Minnesota Statutes 1998, section 169.121 (driver under influence of alcohol or controlled

substance) or 169.129 (aggravated DWI-related violations; penalty). This section applies when the sentence is executed, stayed, or suspended. The court may not waive payment of or authorize payment in installments of the substance use disorder assessment charge and surcharge ~~in installments~~ unless it makes written findings on the record that the convicted person is indigent or that the substance use disorder assessment charge and surcharge would create undue hardship for the convicted person or that person's immediate family.

(b) The ~~chemical dependency~~ substance use disorder assessment charge and surcharge required under this section are in addition to the surcharge required by section 357.021, subdivision 6 (surcharges on criminal and traffic offenders).

(c) The court must not order the person convicted of an offense enumerated in section 169A.70, subdivision 2, to pay the cost of the substance use disorder assessment if the individual is eligible for payment of the assessment under chapter 254B or 256B.

Subd. 2. **Distribution of money.** The court administrator shall collect and forward the ~~chemical dependency~~ substance use disorder assessment charge and the $5 surcharge, if any, to the commissioner of management and budget to be deposited in the state treasury and credited to the general fund.

Sec. 6. Minnesota Statutes 2024, section 245.462, 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 section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university. A case manager who is not a mental health practitioner ~~and~~ or who does not have a bachelor's degree in one of the behavioral sciences or related fields must meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree or with 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 ~~(3)~~ (5):

(1) have ~~three or~~ four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have 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; ~~or~~

(3) be a person who qualified as a case manager under the 1998 Department of Human Service waiver provision and meet the continuing education 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 adults with serious and persistent mental illness that is consistent with national practice standards; or

(5) prior to direct service delivery, demonstrate competency in practice and knowledge of the characteristics and needs of adults with serious and persistent mental illness, consistent with national practice standards.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness 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 remaining 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. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) 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 mental illness and mental health services every two years.

(g) 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 certified peer specialist under section 256B.0615;

(iii) be a registered nurse without a bachelor's degree;

(iv) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in subdivision 20; or as a child had severe emotional disturbance as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(v) have 6,000 hours work experience as a nondegreed state hospital technician; or

(vi) have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (vi) may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive ~~at least 40 hours of~~ annual continuing education in mental illness and mental health services ~~annually; and~~ according to the following schedule, based on years of service as a case management associate:

(i) at least 40 hours in the first year;

(ii) at least 30 hours in the second year;

(iii) at least 20 hours in the third year; and

(iv) at least 20 hours in the fourth year; and

(3) receive at least ~~five~~ four hours of ~~mentoring~~ supervision per ~~week~~ month from a case management ~~mentor~~ supervisor.

~~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.~~

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager 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 a related field including, but not limited to, social work, psychology, or nursing from 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 this subdivision are met.

Sec. 7. Minnesota Statutes 2024, section 245.4661, subdivision 9, is amended to read:

Subd. 9. **Services and programs.** (a) The following three distinct grant programs are funded 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 are eligible for grant funds:

(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.

Sec. 8. Minnesota Statutes 2024, section 245.469, is amended to read:

245.469 EMERGENCY SERVICES.

Subdivision 1. **Availability of emergency services.** (a) County boards must provide or contract for enough emergency services within the county to meet the needs of adults, children, and families in the county who are experiencing an emotional crisis or mental illness. Clients must not be charged for services provided. Emergency service providers must ~~not delay the timely provision of emergency services to a client because of the unwillingness or inability of the client to pay for services~~ meet the qualifications under section 256B.0624, subdivision 4. Emergency services must include assessment, crisis intervention, and appropriate case disposition. Emergency services must:

(1) promote the safety and emotional stability of each client;

(2) minimize further deterioration of each client;

(3) help each client to obtain ongoing care and treatment;

(4) prevent placement in settings that are more intensive, costly, or restrictive than necessary and appropriate to meet client needs; and

(5) provide support, psychoeducation, and referrals to each client's family members, service providers, and other third parties on behalf of the client in need of emergency services.

(b) If a county provides engagement services under section 253B.041, the county's emergency service providers must refer clients to engagement services when the client meets the criteria for engagement services.

Subd. 2. **Specific requirements.** (a) The county board shall require that all service providers of emergency services to adults or children with mental illness provide immediate direct access to a mental health professional during regular business hours. For evenings, weekends, and holidays, the service may be by direct toll-free telephone access to a mental health professional, clinical trainee, or mental health practitioner.

(b) The commissioner may waive the requirement in paragraph (a) that the evening, weekend, and holiday service be provided by a mental health professional, clinical trainee, or mental health practitioner if the county documents that:

(1) mental health professionals, clinical trainees, or mental health practitioners are unavailable to provide this service;

(2) services are provided by a designated person with training in human services who receives treatment supervision from a mental health professional; and

(3) the service provider is not also the provider of fire and public safety emergency services.

(c) The commissioner may waive the requirement in paragraph (b), clause (3), that the evening, weekend, and holiday service not be provided by the provider of fire and public safety emergency services if:

(1) every person who will be providing the first telephone contact has received at least eight hours of training on emergency mental health services approved by the commissioner;

(2) every person who will be providing the first telephone contact will annually receive at least four hours of continued training on emergency mental health services approved by the commissioner;

(3) the local social service agency has provided public education about available emergency mental health services and can assure potential users of emergency services that their calls will be handled appropriately;

(4) the local social service agency agrees to provide the commissioner with accurate data on the number of emergency mental health service calls received;

(5) the local social service agency agrees to monitor the frequency and quality of emergency services; and

(6) the local social service agency describes how it will comply with paragraph (d).

(d) Whenever emergency service during nonbusiness hours is provided by anyone other than a mental health professional, a mental health professional must be available on call for an emergency assessment and crisis intervention services, and must be available for at least telephone consultation within 30 minutes.

Subd. 3. **Mental health crisis services.** The commissioner of human services shall increase access to mental health crisis services for children and adults. In order to increase access, the commissioner must:

(1) ~~develop a central phone number where calls can be routed to the appropriate crisis services~~ promote the 988 Lifeline;

(2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving people with traumatic brain injury or intellectual disabilities who are experiencing a mental health crisis;

(3) expand crisis services across the state, including rural areas of the state and examining access per population;

(4) establish and implement state standards and requirements for crisis services as outlined in section 256B.0624; and

(5) provide grants to adult mental health initiatives, counties, tribes, or community mental health providers to establish new mental health crisis residential service capacity.

Priority will be given to regions that do not have a mental health crisis residential services program, do not have an inpatient psychiatric unit within the region, do not have an inpatient psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis residential or intensive residential treatment beds available to meet the needs of the residents in the region. At least 50 percent of the funds must be distributed to programs in rural Minnesota. Grant funds may be used for start-up costs, including but not limited to renovations, furnishings, and staff training. Grant applications shall provide details on how the intended service will address identified needs and shall demonstrate collaboration with crisis teams, other mental health providers, hospitals, and police.

Sec. 9. Minnesota Statutes 2024, section 245.481, is amended to read:

245.481 FEES FOR MENTAL HEALTH SERVICES.

A client or, in the case of a child, the child or the child's parent may be required to pay a fee for mental health services provided under sections 245.461 to 245.4682, 245.470 to 245.486, and 245.487 to 245.4889. The fee must be based on the person's ability to pay according to the fee schedule adopted by the county board. In adopting the fee schedule for mental health services, the county board may adopt the fee schedule provided by the commissioner or adopt a fee schedule recommended by the county board and approved by the commissioner. Agencies or individuals under contract with a county board to provide mental health services under sections 245.461 to 245.486 and 245.487 to 245.4889 must not charge clients whose mental health services are paid wholly or in part from public funds fees which exceed the county board's adopted fee schedule. This section does not apply to regional treatment center fees, which are governed by sections 246.50 to 246.55.

Sec. 10. Minnesota Statutes 2024, 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 severe emotional disturbance 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 ~~without~~ 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 ~~(3)~~ (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; ~~or~~

(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 emotional disturbance 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 severe emotional disturbance 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 severe emotional disturbance 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 emotional disturbance 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 emotional disturbances; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, 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 severe emotional disturbance 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 severe emotional disturbance 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.

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

Sec. 11. Minnesota Statutes 2024, section 245.4871, is amended by adding a subdivision to read:

Subd. 7a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility for individual treatment plans and individual mental health service delivery, including oversight provided by the case manager. Clinical supervision must be provided by a mental health professional. The supervising mental health professional must cosign an individual treatment plan and the mental health professional's name must be documented in the client's record.

Sec. 12. Minnesota Statutes 2024, section 245.4871, subdivision 31, is amended to read:

Subd. 31. **Professional home-based family treatment.** (a) "Professional home-based family treatment" means intensive mental health services provided to children because of ~~an emotional disturbance~~ mental illness: (1) who are at risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care; (2) who are in ~~out-of-home placement~~ residential treatment or therapeutic foster care; or (3) who are returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care.

(b) Services are provided to the child and the child's family primarily in the child's home environment. Services may also be provided in the child's school, child care setting, or other community setting appropriate to the child. Services must be provided on an individual family basis, must be child-oriented and family-oriented, and must be designed using information from diagnostic and functional assessments to meet the specific mental health needs of the child and the child's family. Services must be coordinated with other services provided to the child and the child's family.

(c) Examples of services are: (1) individual therapy; (2) family therapy; (3) client outreach; (4) assistance in developing individual living skills; (5) assistance in developing parenting skills necessary to address the needs of the child; (6) assistance with leisure and recreational services; (7) crisis planning, including crisis respite care and arranging for crisis placement; and (8) assistance in locating respite and child care. Services must be coordinated with other services provided to the child and family.

Sec. 13. Minnesota Statutes 2024, section 245.4874, subdivision 1, is amended to read:

Subdivision 1. **Duties of county board.** (a) The county board must:

(1) develop a system of affordable and locally available children's mental health services according to sections 245.487 to 245.4889;

(2) consider the assessment of unmet needs in the county as reported by the local children's mental health advisory council under section 245.4875, subdivision 5, paragraph (b), clause (3). The county shall provide,

upon request of the local children's mental health advisory council, readily available data to assist in the determination of unmet needs;

(3) assure that parents and providers in the county receive information about how to gain access to services provided according to sections 245.487 to 245.4889;

(4) coordinate the delivery of children's mental health services with services provided by social services, education, corrections, health, and vocational agencies to improve the availability of mental health services to children and the cost-effectiveness of their delivery;

(5) assure that mental health services delivered according to sections 245.487 to 245.4889 are delivered expeditiously and are appropriate to the child's diagnostic assessment and individual treatment plan;

(6) provide for case management services to each child with ~~severe emotional disturbance~~ serious mental illness according to sections 245.486; 245.4871, subdivisions 3 and 4; and 245.4881, subdivisions 1, 3, and 5;

(7) provide for screening of each child under section 245.4885 upon admission to a residential treatment facility~~, acute care hospital inpatient treatment, or informal admission to a regional treatment center~~;

(8) prudently administer grants and purchase-of-service contracts that the county board determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

(9) assure that mental health professionals, mental health practitioners, and case managers employed by or under contract to the county to provide mental health services are qualified under section 245.4871;

(10) assure that children's mental health services are coordinated with adult mental health services specified in sections 245.461 to 245.486 so that a continuum of mental health services is available to serve persons with mental illness, regardless of the person's age;

(11) assure that culturally competent mental health consultants are used as necessary to assist the county board in assessing and providing appropriate treatment for children of cultural or racial minority heritage; and

(12) consistent with section 245.486, arrange for or provide a children's mental health screening for:

(i) a child receiving child protective services;

(ii) a child in ~~out-of-home placement~~ residential treatment or therapeutic foster care;

(iii) a child for whom parental rights have been terminated;

(iv) a child found to be delinquent; or

(v) a child found to have committed a juvenile petty offense for the third or subsequent time.

A children's mental health screening is not required when a screening or diagnostic assessment has been performed within the previous 180 days, or the child is currently under the care of a mental health professional.

(b) When a child is receiving protective services or is in ~~out-of-home placement~~ residential treatment or foster care, the court or county agency must notify a parent or guardian whose parental rights have not been terminated of the potential mental health screening and the option to prevent the screening by notifying the court or county agency in writing.

(c) When a child is found to be delinquent or a child is found to have committed a juvenile petty offense for the third or subsequent time, the court or county agency must obtain written informed consent from the parent or legal guardian before a screening is conducted unless the court, notwithstanding the parent's failure to consent, determines that the screening is in the child's best interest.

(d) The screening shall be conducted with a screening instrument approved by the commissioner of human services according to criteria that are updated and issued annually to ensure that approved screening instruments are valid and useful for child welfare and juvenile justice populations. Screenings shall be conducted by a mental health practitioner as defined in section 245.4871, subdivision 26, or a probation officer or local social services agency staff person who is trained in the use of the screening instrument. Training in the use of the instrument shall include:

(1) training in the administration of the instrument;

(2) the interpretation of its validity given the child's current circumstances;

(3) the state and federal data practices laws and confidentiality standards;

(4) the parental consent requirement; and

(5) providing respect for families and cultural values.

If the screen indicates a need for assessment, the child's family, or if the family lacks mental health insurance, the local social services agency, in consultation with the child's family, shall have conducted a diagnostic assessment, including a functional assessment. The administration of the screening shall safeguard the privacy of children receiving the screening and their families and shall comply with the Minnesota Government Data Practices Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of 1996, Public Law 104-191. Screening results are classified as private data on individuals, as defined by section 13.02, subdivision 12. The county board or Tribal nation may provide the commissioner with access to the screening results for the purposes of program evaluation and improvement.

(e) When the county board refers clients to providers of children's therapeutic services and supports under section 256B.0943, the county board must clearly identify the desired services components not covered under section 256B.0943 and identify the reimbursement source for those requested services, the method of payment, and the payment rate to the provider.

Sec. 14. Minnesota Statutes 2024, section 245.4881, subdivision 3, is amended to read:

Subd. 3. **Duties of case manager.** (a) Upon a determination of eligibility for case management services, the case manager shall develop an individual family community support plan for a child as specified in subdivision 4, review the child's progress, ~~and~~ monitor the provision of services, and, if the child and the child's parent or legal guardian consent, complete a written functional assessment as defined in section 245.4871, subdivision 18a. If services are to be provided in a host county that is not the county of financial responsibility, the case manager shall consult with the host county and obtain a letter demonstrating the concurrence of the host county regarding the provision of services.

(b) The case manager shall note in the child's record the services needed by the child and the child's family, the services requested by the family, services that are not available, and the unmet needs of the child and child's family. The case manager shall note this provision in the child's record.

Sec. 15. Minnesota Statutes 2024, section 245.4901, subdivision 3, is amended to read:

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses may include but are not limited to:

(1) identifying and diagnosing mental health conditions and substance use disorders of students;

(2) delivering mental health and substance use disorder treatment and services to students and their families, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) supporting families in meeting their child's needs, including accessing needed mental health services to support the child's parent in caregiving and navigating health care, social service, and juvenile justice systems;

(4) providing transportation for students receiving school-linked behavioral health services when school is not in session;

(5) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(6) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees shall obtain all available third-party reimbursement sources as a condition of receiving a grant. For purposes of this grant program, a third-party reimbursement source excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Sec. 16. **[245.4904] INTERMEDIATE SCHOOL DISTRICT BEHAVIORAL HEALTH GRANT PROGRAM.**

Subdivision 1. **Establishment.** The commissioner of human services must establish a grant program to improve behavioral health outcomes for youth attending a qualifying school unit and to build the capacity of schools to support student and teacher needs in the classroom. For purposes of this section, "qualifying school unit" means an intermediate school district organized under section 136D.01.

Subd. 2. **Eligible applicants.** An eligible applicant is an intermediate school district organized under section 136D.01, and a partner entity or provider that has demonstrated capacity to serve the youth identified in subdivision 1 that is:

(1) a mental health clinic certified under section 245I.20;

(2) a community mental health center under section 256B.0625, subdivision 5;

(3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal organization operating under United States Code, title 25, section 5321;

(4) a provider of children's therapeutic services and supports as defined in section 256B.0943;

(5) enrolled in medical assistance as a mental health or substance use disorder provider agency and employs at least two full-time equivalent mental health professionals qualified according to section 245I.04, subdivision 2, or two alcohol and drug counselors licensed or exempt from licensure under chapter 148F who are qualified to provide clinical services to children and families;

(6) licensed under chapter 245G and in compliance with the applicable requirements in chapters 245A, 245C, and 260E; section 626.557; and Minnesota Rules, chapter 9544; or

(7) a licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 254B.05, subdivision 1, paragraph (b).

Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities and related expenses include but are not limited to:

(1) identifying mental health conditions and substance use disorders of students;

(2) delivering mental health and substance use disorder treatment and supportive services to students and their families within the classroom, including via telehealth consistent with section 256B.0625, subdivision 3b;

(3) delivering therapeutic interventions and customizing an array of supplementary learning experiences for students;

(4) supporting families in meeting their child's needs, including navigating health care, social service, and juvenile justice systems;

(5) providing transportation for students receiving behavioral health services when school is not in session;

(6) building the capacity of schools to meet the needs of students with mental health and substance use disorder concerns, including school staff development activities for licensed and nonlicensed staff; and

(7) purchasing equipment, connection charges, on-site coordination, set-up fees, and site fees in order to deliver school-linked behavioral health services via telehealth.

(b) Grantees must obtain all available third-party reimbursement sources as a condition of receiving grant funds. For purposes of this grant program, a third-party reimbursement source does not include a public school as defined in section 120A.20, subdivision 1. Grantees shall serve students regardless of health coverage status or ability to pay.

Subd. 4. **Calculating the share of the appropriation.** (a) Grants must be awarded to qualifying school units proportionately.

(b) The commissioner must calculate the share of the appropriation to be used in each qualifying school unit by multiplying the total appropriation going to the grantees by the qualifying school unit's average daily membership in a setting of federal instructional level 4 or higher and then dividing by the total average daily membership in a setting of federal instructional level 4 or higher for the same year for all qualifying school units.

Subd. 5. **Data collection and outcome measurement.** Grantees must provide data to the commissioner for the purpose of evaluating the Intermediate School District Behavioral Health Innovation grant program. The commissioner must consult with grantees to develop outcome measures for program capacity and performance.

Sec. 17. Minnesota Statutes 2024, section 245.4907, subdivision 3, is amended to read:

Subd. 3. **Allowable grant activities.** Grantees must use grant funding to provide training for mental health ~~certified~~ family peer ~~specialists~~ specialist candidates and continuing education to certified family peer specialists as specified in section 256B.0616, subdivision 5.

Sec. 18. Minnesota Statutes 2024, section 245.50, subdivision 3, is amended to read:

Subd. 3. **Exceptions.** A contract may not be entered into under this section for services to persons who:

(1) are serving a sentence after conviction of a criminal offense;

~~(2) are on probation or parole;~~

~~(3)~~ (2) are the subject of a presentence investigation; or

~~(4)~~ (3) have been committed involuntarily in Minnesota under chapter 253B for treatment of mental illness or chemical dependency, except as provided under subdivision 5.

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

Sec. 19. Minnesota Statutes 2024, section 245.50, is amended by adding a subdivision to read:

Subd. 6. **Contract notice.** A Minnesota mental health, chemical health, or detoxification agency or facility entering into a contract with a bordering state under this section must, within 30 days of the contract's effective date, provide the commissioner of human services with a copy of the contract. If the contract is amended, the agency or facility must provide the commissioner with a copy of each amendment within 30 days of the amendment's effective date.

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

Sec. 20. Minnesota Statutes 2024, section 245F.06, subdivision 2, is amended to read:

Subd. 2. **Comprehensive assessment.** (a) Prior to a medically stable discharge, but not later than 72 hours following admission, a license holder must provide a comprehensive assessment according to sections 245.4863, paragraph (a), and 245G.05, for each patient who has a positive screening for a substance use disorder. If a patient's medical condition prevents a comprehensive assessment from being completed within 72 hours, the license holder must document why the assessment was not completed. The comprehensive assessment must include documentation of the appropriateness of an involuntary referral through the civil commitment process.

(b) If available to the program, a patient's previous comprehensive assessment may be used in the patient record. If a previously completed comprehensive assessment is used, its contents must be reviewed to ensure the assessment is accurate and current and complies with the requirements of this chapter. The review must be completed by a staff person qualified according to section ~~245G.11, subdivision 5~~ 245G.05, subdivision 1. The license holder must document that the review was completed and that the previously completed assessment is accurate and current, or the license holder must complete an updated or new assessment.

Sec. 21. Minnesota Statutes 2024, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** (a) A comprehensive assessment of the client's substance use disorder must be administered face-to-face ~~by an alcohol and drug counselor~~ within five calendar days

from the day of service initiation for a residential program or by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation.

(b) A comprehensive assessment must be administered by:

(1) an alcohol and drug counselor;

(2) a mental health professional who meets the qualifications under section 245I.04, subdivision 2, practices within the scope of their professional licensure, and has at least 12 hours of training in substance use disorder and treatment;

(3) a clinical trainee who meets the qualifications under section 245I.04, subdivision 6, practicing under the supervision of a mental health professional who meets the requirements of clause (2); or

(4) an advanced practice registered nurse as defined in section 148.171, subdivision 3, who practices within the scope of their professional licensure and has at least 12 hours of training in substance use disorder and treatment.

(c) If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client received a comprehensive assessment that authorized the treatment service, ~~an alcohol and drug counselor~~ a staff member qualified under paragraph (b) may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. ~~An alcohol and drug counselor~~ A staff member qualified under paragraph (b) must sign and date the comprehensive assessment review and update.

Sec. 22. Minnesota Statutes 2024, section 245G.11, subdivision 7, is amended to read:

Subd. 7. **Treatment coordination provider qualifications.** (a) Treatment coordination must be provided by qualified staff. An individual is qualified to provide treatment coordination if the individual meets the qualifications of an alcohol and drug counselor under subdivision 5 or if the individual:

(1) is skilled in the process of identifying and assessing a wide range of client needs;

(2) is knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) has ~~successfully~~ completed ~~30~~ 15 hours of ~~classroom instruction on treatment~~ education or training on substance use disorder, co-occurring conditions, and care coordination for ~~an individual~~ individuals with substance use disorder or co-occurring conditions that is consistent with national evidence-based standards;

(4) ~~has either~~ meets one of the following criteria:

(i) has a bachelor's degree in one of the behavioral sciences or related fields; ~~or~~

(ii) ~~current certification as an alcohol and drug counselor, level I, by the Upper Midwest Indian Council on Addictive Disorders; and~~ has a high school diploma or equivalent; or

(iii) is a mental health practitioner who meets the qualifications under section 245I.04, subdivision 4; and

(5) either has at least 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions, or receives treatment supervision at least once per week until obtaining 1,000 hours of supervised experience working with individuals with substance use disorder or co-occurring conditions.

~~(5) has at least 2,000 hours of supervised experience working with individuals with substance use disorder.~~

(b) ~~A treatment coordinator must receive at least one hour of supervision regarding individual service delivery from an alcohol and drug counselor, or a mental health professional who has substance use treatment and assessments within the scope of their practice, on a monthly basis.~~ A treatment coordinator must receive the following levels of supervision from an alcohol and drug counselor or a mental health professional whose scope of practice includes substance use disorder treatment and assessments:

(1) for a treatment coordinator that has not obtained 1,000 hours of supervised experience under paragraph (a), clause (5), at least one hour of supervision per week; or

(2) for a treatment coordinator that has obtained at least 1,000 hours of supervised experience under paragraph (a), clause (5), at least one hour of supervision per month.

Sec. 23. Minnesota Statutes 2024, section 245I.05, subdivision 3, is amended to read:

Subd. 3. **Initial training.** (a) A staff person must receive training about:

(1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

(2) the maltreatment of minor reporting requirements and definitions in chapter 260E within 72 hours of first providing direct contact services to a client.

(b) Before providing direct contact services to a client, a staff person must receive training about:

(1) client rights and protections under section 245I.12;

(2) the Minnesota Health Records Act, including client confidentiality, family engagement under section 144.294, and client privacy;

(3) emergency procedures that the staff person must follow when responding to a fire, inclement weather, a report of a missing person, and a behavioral or medical emergency;

(4) specific activities and job functions for which the staff person is responsible, including the license holder's program policies and procedures applicable to the staff person's position;

(5) professional boundaries that the staff person must maintain; and

(6) specific needs of each client to whom the staff person will be providing direct contact services, including each client's developmental status, cognitive functioning, and physical and mental abilities.

(c) Before providing direct contact services to a client, a mental health rehabilitation worker, mental health behavioral aide, or mental health practitioner required to receive the training according to section 245I.04, subdivision 4, must receive 30 hours of training about:

(1) mental illnesses;

(2) client recovery and resiliency;

(3) mental health de-escalation techniques;

(4) co-occurring mental illness and substance use disorders; and

(5) psychotropic medications and medication side effects, including tardive dyskinesia.

(d) Within 90 days of first providing direct contact services to an adult client, mental health practitioner, mental health certified peer specialist, or mental health rehabilitation worker must receive training about:

(1) trauma-informed care and secondary trauma;

(2) person-centered individual treatment plans, including seeking partnerships with family and other natural supports;

(3) co-occurring substance use disorders; and

(4) culturally responsive treatment practices.

(e) Within 90 days of first providing direct contact services to a child client, mental health practitioner, mental health certified family peer specialist, mental health certified peer specialist, or mental health behavioral aide must receive training about the topics in clauses (1) to (5). This training must address the developmental characteristics of each child served by the license holder and address the needs of each child in the context of the child's family, support system, and culture. Training topics must include:

(1) trauma-informed care and secondary trauma, including adverse childhood experiences (ACEs);

(2) family-centered treatment plan development, including seeking partnership with a child client's family and other natural supports;

(3) mental illness and co-occurring substance use disorders in family systems;

(4) culturally responsive treatment practices; and

(5) child development, including cognitive functioning, and physical and mental abilities.

(f) For a mental health behavioral aide, the training under paragraph (e) must include parent team training using a curriculum approved by the commissioner.

Sec. 24. Minnesota Statutes 2024, section 245I.05, subdivision 5, is amended to read:

Subd. 5. **Additional training for medication administration.** (a) Prior to administering medications to a client under delegated authority or observing a client self-administer medications, a staff person who is not a licensed prescriber, registered nurse, or licensed practical nurse qualified under section 148.171, subdivision 8, must receive training about psychotropic medications, side effects including tardive dyskinesia, and medication management.

(b) Prior to administering medications to a client under delegated authority, a staff person must successfully complete a:

(1) medication administration training program for unlicensed personnel through an accredited Minnesota postsecondary educational institution with completion of the course documented in writing and placed in the staff person's personnel file; or

(2) formalized training program taught by a registered nurse or licensed prescriber that is offered by the license holder. A staff person's successful completion of the formalized training program must include direct observation of the staff person to determine the staff person's areas of competency.

Sec. 25. Minnesota Statutes 2024, 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 mental 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 ~~for the observed treatment service~~ 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 file.

(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. 26. Minnesota Statutes 2024, section 245I.11, subdivision 5, is amended to read:

Subd. 5. **Medication administration in residential programs.** If a license holder is licensed as a residential program, the license holder must:

(1) assess and document each client's ability to self-administer medication. In the assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed medication regimens; and (ii) store the client's medications safely and in a manner that protects other individuals in the facility. Through the assessment process, the license holder must assist the client in developing the skills necessary to safely self-administer medication;

(2) monitor the effectiveness of medications, side effects of medications, and adverse reactions to medications, including symptoms and signs of tardive dyskinesia, for each client. The license holder must address and document any concerns about a client's medications;

(3) ensure that no staff person or client gives a legend drug supply for one client to another client;

(4) have policies and procedures for: (i) keeping a record of each client's medication orders; (ii) keeping a record of any incident of deferring a client's medications; (iii) documenting any incident when a client's medication is omitted; and (iv) documenting when a client refuses to take medications as prescribed; and

(5) document and track medication errors, document whether the license holder notified anyone about the medication error, determine if the license holder must take any follow-up actions, and identify the staff persons who are responsible for taking follow-up actions.

Sec. 27. Minnesota Statutes 2024, section 245I.12, subdivision 5, is amended to read:

Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure that:

(1) describes to clients how the license holder will meet the requirements in this subdivision; and

(2) contains the current public contact information of the Department of Human Services, Licensing Division; the Office of Ombudsman for Mental Health and Developmental Disabilities; the Department of Health, Office of Health Facilities Complaints; and all applicable health-related licensing boards.

(b) On the day of each client's admission, the license holder must explain the grievance procedure to the client.

(c) The license holder must:

(1) post the grievance procedure in a place visible to clients and provide a copy of the grievance procedure upon request;

(2) allow clients, former clients, and their authorized representatives to submit a grievance to the license holder;

(3) within three business days of receiving a client's grievance, acknowledge in writing that the license holder received the client's grievance. If applicable, the license holder must include a notice of the client's separate appeal rights for a managed care organization's reduction, termination, or denial of a covered service;

(4) within 15 business days of receiving a client's grievance, provide a written final response to the client's grievance containing the license holder's official response to the grievance; and

(5) allow the client to bring a grievance to the person with the highest level of authority in the program.

(d) Clients may voice grievances and recommend changes in policies and services to staff and others of their choice, free from restraint, interference, coercion, discrimination, or reprisal, including threat of discharge.

Sec. 28. Minnesota Statutes 2024, section 254A.03, subdivision 1, is amended to read:

Subdivision 1. **Alcohol and Other Drug Abuse Section.** There is hereby created an Alcohol and Other Drug Abuse Section in the Department of Human Services. This section shall be headed by a director. The commissioner may place the director's position in the unclassified service if the position meets the criteria established in section 43A.08, subdivision 1a. The section shall:

(1) conduct and foster basic research relating to the cause, prevention and methods of diagnosis, treatment and recovery of persons with substance misuse and substance use disorder;

~~(2) coordinate and review all activities and programs of all the various state departments as they relate to problems associated with substance misuse and substance use disorder;~~

~~(3)~~ (2) develop, demonstrate, and disseminate new methods and techniques for prevention, early intervention, treatment and recovery support for substance misuse and substance use disorder;

~~(4)~~ (3) gather facts and information about substance misuse and substance use disorder, and about the efficiency and effectiveness of prevention, treatment, and recovery support services from all comprehensive programs, including programs approved or licensed by the commissioner of human services or the commissioner of health or accredited by the Joint Commission on Accreditation of Hospitals. The state authority is authorized to require information from comprehensive programs which is reasonable and necessary to fulfill these duties. When required information has been previously furnished to a state or local governmental agency, the state authority shall collect the information from the governmental agency. The

state authority shall disseminate facts and summary information about problems associated with substance misuse and substance use disorder to public and private agencies, local governments, local and regional planning agencies, and the courts for guidance to and assistance in prevention, treatment and recovery support;

~~(5)~~ (4) inform and educate the general public on substance misuse and substance use disorder;

~~(6)~~ (5) serve as the state authority concerning substance misuse and substance use disorder by monitoring the conduct of diagnosis and referral services, research and comprehensive programs. The state authority shall submit a biennial report to the governor containing a description of public services delivery and recommendations concerning increase of coordination and quality of services, and decrease of service duplication and cost;

~~(7) establish a state plan which shall set forth goals and priorities for a comprehensive continuum of care for substance misuse and substance use disorder for Minnesota. All state agencies operating substance misuse or substance use disorder programs or administering state or federal funds for such programs shall annually set their program goals and priorities in accordance with the state plan. Each state agency shall annually submit its plans and budgets to the state authority for review. The state authority shall certify whether proposed services comply with the comprehensive state plan and advise each state agency of review findings;~~

~~(8)~~ (6) make contracts with and grants to public and private agencies and organizations, both profit and nonprofit, and individuals, using federal funds, and state funds as authorized to pay for costs of state administration, including evaluation, statewide programs and services, research and demonstration projects, and American Indian programs;

~~(9)~~ (7) receive and administer money available for substance misuse and substance use disorder programs under the alcohol, drug abuse, and mental health services block grant, United States Code, title 42, sections 300X to 300X-9;

~~(10)~~ (8) solicit and accept any gift of money or property for purposes of Laws 1973, chapter 572, and any grant of money, services, or property from the federal government, the state, any political subdivision thereof, or any private source; and

~~(11)~~ (9) with respect to substance misuse and substance use disorder programs serving the American Indian community, establish guidelines for the employment of personnel with considerable practical experience in substance misuse and substance use disorder, and understanding of social and cultural problems related to substance misuse and substance use disorder, in the American Indian community.

Sec. 29. Minnesota Statutes 2024, section 254A.19, subdivision 6, is amended to read:

Subd. 6. **Assessments for detoxification programs.** For detoxification programs licensed under chapter 245A according to Minnesota Rules, parts 9530.6510 to 9530.6590, a "chemical use assessment" is a comprehensive assessment completed according to the requirements of section 245G.05 ~~and a "chemical dependency assessor" or "assessor" is an individual who meets the qualifications of section 245G.11, subdivisions 1 and 5~~.

Sec. 30. Minnesota Statutes 2024, section 254A.19, subdivision 7, is amended to read:

Subd. 7. **Assessments for children's residential facilities.** For children's residential facilities licensed under chapter 245A according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0430 to 2960.0490,

a "chemical use assessment" is a comprehensive assessment completed according to the requirements of section 245G.05 ~~and must be completed by an individual who meets the qualifications of section 245G.11, subdivisions 1 and 5~~.

Sec. 31. Minnesota Statutes 2024, section 254B.05, subdivision 1, is amended to read:

Subdivision 1. **Licensure or certification required.** (a) Programs licensed by the commissioner are eligible vendors. Hospitals may apply for and receive licenses to be eligible vendors, notwithstanding the provisions of section 245A.03. American Indian programs that provide substance use disorder treatment, extended care, transitional residence, or outpatient treatment services, and are licensed by tribal government are eligible vendors.

(b) A licensed professional in private practice as defined in section 245G.01, subdivision 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible vendor of a comprehensive assessment provided according to section 254A.19, subdivision 3, and treatment services provided according to sections 245G.06 and 245G.07, subdivision 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

(c) A county is an eligible vendor for a comprehensive assessment when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5, and completed according to the requirements of section 254A.19, subdivision 3. A county is an eligible vendor of care coordination services when provided by an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5). A county is an eligible vendor of peer recovery services when the services are provided by an individual who meets the requirements of section 245G.11, subdivision 8.

(d) A recovery community organization that meets the requirements of clauses (1) to ~~(14)~~ (15) and meets certification ~~or accreditation~~ requirements of the ~~Alliance for Recovery Centered Organizations, the Council on Accreditation of Peer Recovery Support Services,~~ Minnesota Alliance of Recovery Community Organizations or ~~a~~ another Minnesota statewide recovery organization identified by the commissioner is an eligible vendor of peer recovery support services. If the commissioner does not identify another statewide recovery organization, or the Minnesota Alliance of Recovery Community Organizations or the statewide recovery organization identified by the commissioner is not reasonably positioned to certify vendors, the commissioner must determine the eligibility of a vendor of peer recovery support services. A Minnesota statewide recovery organization identified by the commissioner must update recovery community organization applicants for certification ~~or accreditation~~ on the status of the application within 45 days of receipt. If the approved statewide recovery organization denies an application, it must provide a written explanation for the denial to the recovery community organization. Eligible vendors under this paragraph must:

(1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be free from conflicting self-interests, and be autonomous in decision-making, program development, peer recovery support services provided, and advocacy efforts for the purpose of supporting the recovery community organization's mission;

(2) be led and governed by individuals in the recovery community, with more than 50 percent of the board of directors or advisory board members self-identifying as people in personal recovery from substance use disorders;

(3) have a mission statement and conduct corresponding activities indicating that the organization's primary purpose is to support recovery from substance use disorder;

(4) demonstrate ongoing community engagement with the identified primary region and population served by the organization, including individuals in recovery and their families, friends, and recovery allies;

(5) be accountable to the recovery community through documented priority-setting and participatory decision-making processes that promote the engagement of, and consultation with, people in recovery and their families, friends, and recovery allies;

(6) provide nonclinical peer recovery support services, including but not limited to recovery support groups, recovery coaching, telephone recovery support, skill-building, and harm-reduction activities, and provide recovery public education and advocacy;

(7) have written policies that allow for and support opportunities for all paths toward recovery and refrain from excluding anyone based on their chosen recovery path, which may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based paths;

(8) maintain organizational practices to meet the needs of Black, Indigenous, and people of color communities, LGBTQ+ communities, and other underrepresented or marginalized communities. Organizational practices may include board and staff training, service offerings, advocacy efforts, and culturally informed outreach and services;

(9) use recovery-friendly language in all media and written materials that is supportive of and promotes recovery across diverse geographical and cultural contexts and reduces stigma;

(10) establish and maintain a publicly available recovery community organization code of ethics and grievance policy and procedures;

(11) not classify or treat any recovery peer hired on or after July 1, 2024, as an independent contractor;

(12) not classify or treat any recovery peer as an independent contractor on or after January 1, 2025;

(13) provide an orientation for recovery peers that includes an overview of the consumer advocacy services provided by the Ombudsman for Mental Health and Developmental Disabilities and other relevant advocacy services; ~~and~~

(14) provide notice to peer recovery support services participants that includes the following statement: "If you have a complaint about the provider or the person providing your peer recovery support services, you may contact the Minnesota Alliance of Recovery Community Organizations. You may also contact the Office of Ombudsman for Mental Health and Developmental Disabilities." The statement must also include:

(i) the telephone number, website address, email address, and mailing address of the Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman for Mental Health and Developmental Disabilities;

(ii) the recovery community organization's name, address, email, telephone number, and name or title of the person at the recovery community organization to whom problems or complaints may be directed; and

(iii) a statement that the recovery community organization will not retaliate against a peer recovery support services participant because of a complaint~~.~~; and

(15) comply with the requirements of section 245A.04, subdivision 15a.

(e) A recovery community organization approved by the commissioner before June 30, 2023, must have begun the application process as required by an approved certifying or accrediting entity and have begun the process to meet the requirements under paragraph (d) by September 1, 2024, in order to be considered as an eligible vendor of peer recovery support services.

(f) A recovery community organization that is aggrieved by ~~an accreditation,~~ a certification~~, or membership~~ determination and believes it meets the requirements under paragraph (d) may appeal the determination under section 256.045, subdivision 3, paragraph (a), clause (14), for reconsideration as an eligible vendor. If the human services judge determines that the recovery community organization meets the requirements under paragraph (d), the recovery community organization is an eligible vendor of peer recovery support services for up to two years from the date of the determination. After two years, the recovery community organization must apply for certification under paragraph (d) to continue to be an eligible vendor of peer recovery support services.

(g) All recovery community organizations must be certified ~~or accredited~~ by an entity listed in paragraph (d) by June 30, ~~2025~~ 2027.

(h) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or nonresidential substance use disorder treatment or withdrawal management program by the commissioner or by tribal government or do not meet the requirements of subdivisions 1a and 1b are not eligible vendors.

(i) Hospitals, federally qualified health centers, and rural health clinics are eligible vendors of a comprehensive assessment when the comprehensive assessment is completed according to section 254A.19, subdivision 3, and by an individual who meets the criteria of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol and drug counselor must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service.

(j) Any complaints about a recovery community organization or peer recovery support services may be made to and reviewed or investigated by the ombudsperson for behavioral health and developmental disabilities under sections 245.91 and 245.94.

Sec. 32. Minnesota Statutes 2024, section 254B.05, subdivision 5, is amended to read:

Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance use disorder services and service enhancements funded under this chapter.

(b) Eligible substance use disorder treatment services include:

(1) those licensed, as applicable, according to chapter 245G or applicable Tribal license and provided according to the following ASAM levels of care:

(i) ASAM level 0.5 early intervention services provided according to section 254B.19, subdivision 1, clause (1);

(ii) ASAM level 1.0 outpatient services provided according to section 254B.19, subdivision 1, clause (2);

(iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19, subdivision 1, clause (3);

(iv) ASAM level 2.5 partial hospitalization services provided according to section 254B.19, subdivision 1, clause (4);

(v) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5). The commissioner shall use the base payment rate of $79.84 per day for services provided under this item;

(vi) ASAM level 3.1 clinically managed low-intensity residential services provided according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled treatment services each week. The commissioner shall use the base payment rate of $166.13 per day for services provided under this item;

(vii) ASAM level 3.3 clinically managed population-specific high-intensity residential services provided according to section 254B.19, subdivision 1, clause (6). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item; and

(viii) ASAM level 3.5 clinically managed high-intensity residential services provided according to section 254B.19, subdivision 1, clause (7). The commissioner shall use the specified base payment rate of $224.06 per day for services provided under this item;

(2) comprehensive assessments provided according to section 254A.19, subdivision 3;

(3) treatment coordination services provided according to section 245G.07, subdivision 1, paragraph (a), clause (5);

(4) peer recovery support services provided according to section 245G.07, subdivision 2, clause (8);

(5) withdrawal management services provided according to chapter 245F;

(6) hospital-based treatment services that are licensed according to sections 245G.01 to 245G.17 or applicable Tribal license and licensed as a hospital under sections 144.50 to 144.56;

(7) substance use disorder treatment services with medications for opioid use disorder provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17 and 245G.22, or under an applicable Tribal license;

(8) medium-intensity residential treatment services that provide 15 hours of skilled treatment services each week and are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license;

(9) adolescent treatment programs that are licensed as outpatient treatment programs according to sections 245G.01 to 245G.18 or as residential treatment programs according to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or applicable Tribal license;

(10) ASAM 3.5 clinically managed high-intensity residential services that are licensed according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license, which provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7), and are provided by a state-operated vendor or to clients who have been civilly committed to the commissioner, present the most complex and difficult care needs, and are a potential threat to the community; and

(11) room and board facilities that meet the requirements of subdivision 1a.

(c) The commissioner shall establish higher rates for programs that meet the requirements of paragraph (b) and one of the following additional requirements:

(1) programs that serve parents with their children if the program:

(i) provides on-site child care during the hours of treatment activity that:

(A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter 9503; or

(B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or

(ii) arranges for off-site child care during hours of treatment activity at a facility that is licensed under chapter 245A as:

(A) a child care center under Minnesota Rules, chapter 9503; or

(B) a family child care home under Minnesota Rules, chapter 9502;

(2) culturally specific or culturally responsive programs as defined in section 254B.01, subdivision 4a;

(3) disability responsive programs as defined in section 254B.01, subdivision 4b;

(4) programs that offer medical services delivered by appropriately credentialed health care staff in an amount equal to one hour per client per week if the medical needs of the client and the nature and provision of any medical services provided are documented in the client file; or

(5) programs that offer services to individuals with co-occurring mental health and substance use disorder problems if:

(i) the program meets the co-occurring requirements in section 245G.20;

(ii) the program employs a mental health professional as defined in section 245I.04, subdivision 2;

(iii) clients scoring positive on a standardized mental health screen receive a mental health diagnostic assessment within ten days of admission, excluding weekends and holidays;

(iv) the program has standards for multidisciplinary case review that include a monthly review for each client that, at a minimum, includes a licensed mental health professional and licensed alcohol and drug counselor, and their involvement in the review is documented;

(v) family education is offered that addresses mental health and substance use disorder and the interaction between the two; and

(vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder training annually.

(d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program that provides arrangements for off-site child care must maintain current documentation at the substance use disorder facility of the child care provider's current licensure to provide child care services.

(e) Adolescent residential programs that meet the requirements of Minnesota Rules, parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements in paragraph (c), clause (5), items (i) to (iv).

(f) Substance use disorder services that are otherwise covered as direct face-to-face services may be provided via telehealth as defined in section 256B.0625, subdivision 3b. The use of telehealth to deliver services must be medically appropriate to the condition and needs of the person being served. Reimbursement shall be at the same rates and under the same conditions that would otherwise apply to direct face-to-face services.

(g) For the purpose of reimbursement under this section, substance use disorder treatment services provided in a group setting without a group participant maximum or maximum client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one. At least one of the attending staff must meet the qualifications as established under this chapter for the type of treatment service provided. A recovery peer may not be included as part of the staff ratio.

(h) Payment for outpatient substance use disorder services that are licensed according to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless prior authorization of a greater number of hours is obtained from the commissioner.

(i) Payment for substance use disorder services under this section must start from the day of service initiation, when the comprehensive assessment is completed within the required timelines.

(j) A license holder that is unable to provide all residential treatment services because a client missed services remains eligible to bill for the client's intensity level of services under this paragraph if the license holder can document the reason the client missed services and the interventions done to address the client's absence.

(k) Hours in a treatment week may be reduced in observance of federally recognized holidays.

(l) Eligible vendors of peer recovery support services must:

(1) submit to a review by the commissioner of up to ten percent of all medical assistance and behavioral health fund claims to determine the medical necessity of peer recovery support services for entities billing for peer recovery support services individually and not receiving a daily rate; and

(2) limit an individual client to 14 hours per week for peer recovery support services from an individual provider of peer recovery support services.

(m) Peer recovery support services not provided in accordance with section 254B.052 are subject to monetary recovery under section 256B.064 as money improperly paid.

Sec. 33. Minnesota Statutes 2024, section 254B.06, is amended by adding a subdivision to read:

Subd. 5. **Prohibition of duplicative claim submission.** (a) For time-based claims, submissions must follow the guidelines in the Centers for Medicare and Medicaid Services' Healthcare Common Procedure Coding System and the American Medical Association's Current Procedural Terminology to determine the appropriate units of time to report.

(b) More than half the duration of a time-based code must be spent performing the service to be eligible under this section. Any other claim submission for service provided during the remaining balance of the unit of time is duplicative and ineligible.

(c) A provider may only round up to the next whole number of service units on a submitted claim when more than one and one-half times the defined value of the code has occurred and no additional time increment code exists.

EFFECTIVE DATE. This section is effective July 1, 2025.

Sec. 34. Minnesota Statutes 2024, section 256.01, subdivision 34, is amended to read:

Subd. 34. **Federal administrative reimbursement dedicated.** Federal administrative reimbursement resulting from the following activities is appropriated to the commissioner for the designated purposes:

(1) reimbursement for the Minnesota senior health options project; ~~and~~

(2) reimbursement related to prior authorization, review of medical necessity, and inpatient admission certification by a professional review organization. A portion of these funds must be used for activities to decrease unnecessary pharmaceutical costs in medical assistance~~.~~; and

(3) reimbursement for capacity building and implementation grant expenditures for the medical assistance reentry demonstration waiver under section 256B.0761.

Sec. 35. Minnesota Statutes 2024, section 256B.0616, subdivision 4, is amended to read:

Subd. 4. **Family peer support ~~specialist~~ program providers.** The commissioner shall develop a process to certify family peer support ~~specialist~~ programs, in accordance with the federal guidelines, in order for the program to bill for reimbursable services. Family peer support programs must operate within an existing mental health community provider or center.

Sec. 36. Minnesota Statutes 2024, section 256B.0616, subdivision 5, is amended to read:

Subd. 5. **Certified family peer specialist training and certification.** (a) The commissioner shall develop ~~a~~ or approve the use of an existing training and certification process for ~~certified~~ certifying family peer specialists. ~~The~~ Family peer specialist candidates must have raised or be currently raising a child with a mental illness~~,~~; have ~~had~~ experience navigating the children's mental health system~~,~~; and ~~must~~ demonstrate leadership and advocacy skills and a strong dedication to family-driven and family-focused services. The training curriculum must teach participating family peer ~~specialists~~ specialist candidates specific skills relevant to providing peer support to other parents and youth.

(b) In addition to initial training and certification, the commissioner shall develop ongoing continuing educational workshops on pertinent issues related to family peer support counseling.

(c) Initial training leading to certification as a family peer specialist and continuing education for certified family peer specialists must be delivered by the commissioner or a third-party organization approved by the commissioner. An approved third-party organization may also provide continuing education of certified family peer specialists.

Sec. 37. Minnesota Statutes 2024, section 256B.0622, subdivision 3a, is amended to read:

Subd. 3a. **Provider certification and contract requirements for assertive community treatment.** (a) The assertive community treatment provider must have each ACT team be certified by the state following the certification process and procedures developed by the commissioner. The certification process determines whether the ACT team meets the standards for assertive community treatment under this section, the standards in chapter 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards as measured by a nationally recognized fidelity tool approved by the commissioner. Recertification must occur at least every three years.

(b) An ACT team certified under this subdivision must meet the following standards:

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

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

(3) ensure flexibility in service delivery to respond to the changing and intermittent care needs of a client as identified by the client and the individual treatment plan;

(4) keep all necessary records required by law;

(5) be an enrolled Medicaid provider; ~~and~~

(6) establish and maintain a quality assurance plan to determine specific service outcomes and the client's satisfaction with services~~.~~; and

(7) ensure that overall treatment supervision to the ACT team is provided by a qualified member of the ACT team and is available during and after regular business hours and on weekends and holidays.

(c) The commissioner may intervene at any time and decertify an ACT team with cause. The commissioner shall establish a process for decertification of an ACT team and shall require corrective action, medical assistance repayment, or decertification of an ACT team that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process. The decertification is subject to appeal to the state.

Sec. 38. Minnesota Statutes 2024, section 256B.0622, subdivision 7a, is amended to read:

Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a) The required treatment staff qualifications and roles for an ACT team are:

(1) the team leader:

(i) ~~shall~~ must be a mental health professional~~. Individuals who are not licensed but who are eligible for licensure and are otherwise qualified may also fulfill this role~~, clinical trainee, or mental health practitioner;

(ii) must be an active member of the ACT team and provide some direct services to clients;

(iii) must be a single full-time staff member, dedicated to the ACT team, who is responsible for overseeing the administrative operations of the team and supervising team members to ensure delivery of best and ethical practices; and

(iv) must be available to ensure that overall treatment supervision to the ACT team is available after regular business hours and on weekends and holidays and is provided by a qualified member of the ACT team;

(2) the psychiatric care provider:

(i) must be a mental health professional permitted to prescribe psychiatric medications as part of the mental health professional's scope of practice. The psychiatric care provider must have demonstrated clinical experience working with individuals with serious and persistent mental illness;

(ii) shall collaborate with the team leader in sharing overall clinical responsibility for screening and admitting clients; monitoring clients' treatment and team member service delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects, and health-related conditions; actively collaborating with nurses; and helping provide treatment supervision to the team;

(iii) shall fulfill the following functions for assertive community treatment clients: provide assessment and treatment of clients' symptoms and response to medications, including side effects; provide brief therapy

to clients; provide diagnostic and medication education to clients, with medication decisions based on shared decision making; monitor clients' nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and community visits;

(iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized for mental health treatment and shall communicate directly with the client's inpatient psychiatric care providers to ensure continuity of care;

(v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per 50 clients. Part-time psychiatric care providers shall have designated hours to work on the team, with sufficient blocks of time on consistent days to carry out the provider's clinical, supervisory, and administrative responsibilities. No more than two psychiatric care providers may share this role; and

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

(3) the nursing staff:

(i) shall consist of one to three registered nurses or advanced practice registered nurses, of whom at least one has a minimum of one-year experience working with adults with serious mental illness and a working knowledge of psychiatric medications. No more than two individuals can share a full-time equivalent position;

(ii) are responsible for managing medication, administering and documenting medication treatment, and managing a secure medication room; and

(iii) shall develop strategies, in collaboration with clients, to maximize taking medications as prescribed; screen and monitor clients' mental and physical health conditions and medication side effects; engage in health promotion, prevention, and education activities; communicate and coordinate services with other medical providers; facilitate the development of the individual treatment plan for clients assigned; and educate the ACT team in monitoring psychiatric and physical health symptoms and medication side effects;

(4) the co-occurring disorder specialist:

(i) shall be a full-time equivalent co-occurring disorder specialist who has received specific training on co-occurring disorders that is consistent with national evidence-based practices. The training must include practical knowledge of common substances and how they affect mental illnesses, the ability to assess substance use disorders and the client's stage of treatment, motivational interviewing, and skills necessary to provide counseling to clients at all different stages of change and treatment. The co-occurring disorder specialist may also be an individual who is a licensed alcohol and drug counselor as described in section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience, and other requirements in section 245G.11, subdivision 5. No more than two co-occurring disorder specialists may occupy this role; and

(ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients. The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT team members on co-occurring disorders;

(5) the vocational specialist:

(i) shall be a full-time vocational specialist who has at least one-year experience providing employment services or advanced education that involved field training in vocational services to individuals with mental

illness. An individual who does not meet these qualifications may also serve as the vocational specialist upon completing a training plan approved by the commissioner;

(ii) shall provide or facilitate the provision of vocational services to clients. The vocational specialist serves as a consultant and educator to fellow ACT team members on these services; and

(iii) must not refer individuals to receive any type of vocational services or linkage by providers outside of the ACT team;

(6) the mental health certified peer specialist:

(i) shall be a full-time equivalent. No more than two individuals can share this position. The mental health certified peer specialist is a fully integrated team member who provides highly individualized services in the community and promotes the self-determination and shared decision-making abilities of clients. This requirement may be waived due to workforce shortages upon approval of the commissioner;

(ii) must provide coaching, mentoring, and consultation to the clients to promote recovery, self-advocacy, and self-direction, promote wellness management strategies, and assist clients in developing advance directives; and

(iii) must model recovery values, attitudes, beliefs, and personal action to encourage wellness and resilience, provide consultation to team members, promote a culture where the clients' points of view and preferences are recognized, understood, respected, and integrated into treatment, and serve in a manner equivalent to other team members;

(7) the program administrative assistant shall be a full-time office-based program administrative assistant position assigned to solely work with the ACT team, providing a range of supports to the team, clients, and families; and

(8) additional staff:

(i) shall be based on team size. Additional treatment team staff may include mental health professionals; clinical trainees; certified rehabilitation specialists; mental health practitioners; or mental health rehabilitation workers. These individuals shall have the knowledge, skills, and abilities required by the population served to carry out rehabilitation and support functions; and

(ii) shall be selected based on specific program needs or the population served.

(b) Each ACT team must clearly document schedules for all ACT team members.

(c) Each ACT team member must serve as a primary team member for clients assigned by the team leader and are responsible for facilitating the individual treatment plan process for those clients. The primary team member for a client is the responsible team member knowledgeable about the client's life and circumstances and writes the individual treatment plan. The primary team member provides individual supportive therapy or counseling, and provides primary support and education to the client's family and support system.

(d) Members of the ACT team must have strong clinical skills, professional qualifications, experience, and competency to provide a full breadth of rehabilitation services. Each staff member shall be proficient in their respective discipline and be able to work collaboratively as a member of a multidisciplinary team to deliver the majority of the treatment, rehabilitation, and support services clients require to fully benefit from receiving assertive community treatment.

(e) Each ACT team member must fulfill training requirements established by the commissioner.

EFFECTIVE DATE. This section is effective upon federal approval. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 39. Minnesota Statutes 2024, section 256B.0761, subdivision 4, is amended to read:

Subd. 4. **Services and duration.** (a) Services must be provided 90 days prior to an individual's release date or, if an individual's confinement is less than 90 days, during the time period between a medical assistance eligibility determination and the release to the community.

(b) Facilities must offer the following services using either community-based or corrections-based providers:

(1) case management activities to address physical and behavioral health needs, including a comprehensive assessment of individual needs, development of a person-centered care plan, referrals and other activities to address assessed needs, and monitoring and follow-up activities;

(2) drug coverage in accordance with section 256B.0625, subdivision 13, including up to a 30-day supply of drugs upon release;

(3) substance use disorder comprehensive assessments according to section 254B.05, subdivision 5, paragraph (b), clause (2);

(4) treatment coordination services according to section 254B.05, subdivision 5, paragraph (b), clause (3);

(5) peer recovery support services according to sections 245I.04, subdivisions 18 and 19, and 254B.05, subdivision 5, paragraph (b), clause (4);

(6) substance use disorder individual and group counseling provided according to sections 245G.07, subdivision 1, paragraph (a), clause (1), and 254B.05;

(7) mental health diagnostic assessments as required under section 245I.10;

(8) group and individual psychotherapy as required under section 256B.0671;

(9) peer specialist services as required under sections 245I.04 and 256B.0615;

(10) family planning and obstetrics and gynecology services; ~~and~~

(11) physical health well-being and screenings and care for adults and youth~~.~~; and

(12) medications used for the treatment of opioid use disorder and nonmedication treatment services for opioid use disorder under section 245G.22.

(c) Services outlined in this subdivision must only be authorized when an individual demonstrates medical necessity or other eligibility as required under this chapter or applicable state and federal laws.

Sec. 40. Minnesota Statutes 2024, section 256L.03, subdivision 5, is amended to read:

Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to children under the age of 21 and to American Indians as defined in Code of Federal Regulations, title 42, section 600.5.

(b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent. The cost-sharing changes described in this paragraph do not apply to eligible recipients or services exempt from cost-sharing under state law. The cost-sharing changes described in this paragraph shall not be implemented prior to January 1, 2016.

(c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations, title 42, sections 600.510 and 600.520.

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

(e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic services or testing that a health care provider determines an enrollee requires after a mammogram, as specified under section 62A.30, subdivision 5.

(f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

(g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of the human immunodeficiency virus (HIV).

(h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention or crisis assessment as defined in section 256B.0624, subdivision 2.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 41. **REVISOR INSTRUCTION.**

The revisor of statutes shall substitute the term "substance use disorder assessment" or similar terms for "chemical dependency assessment" or similar terms, for "chemical use assessment" or similar terms, and for "comprehensive substance use disorder assessment" or similar terms wherever they appear in Minnesota Statutes, chapter 169A, and Minnesota Rules, chapter 7503, when referring to the assessments required under Minnesota Statutes, section 169A.70, or the charges or surcharges associated with those assessments.

Sec. 42. **REVISOR INSTRUCTION.**

The revisor of statutes shall change the terms "sober home" and "sober homes" to "recovery residence" or "recovery residences" wherever they appear in Minnesota Statutes.

ARTICLE 5

DEPARTMENT OF HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

Section 1. Minnesota Statutes 2024, section 142E.51, subdivision 5, is amended to read:

Subd. 5. **Administrative disqualification of child care providers caring for children receiving child care assistance.** (a) The department shall pursue an administrative disqualification~~,~~ if the child care provider

is accused of committing an intentional program violation, in lieu of a criminal action when it has not been pursued. Intentional program violations include intentionally making false or misleading statements; intentionally offering, providing, soliciting, or receiving illegal remuneration as described in subdivision 6a or in violation of section 609.542, subdivision 2; intentionally misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating program regulations under this chapter. Intent may be proven by demonstrating a pattern of conduct that violates program rules under this chapter.

(b) To initiate an administrative disqualification, the commissioner must send written notice using a signature-verified confirmed delivery method to the provider against whom the action is being taken. Unless otherwise specified under this chapter or Minnesota Rules, chapter 3400, the commissioner must send the written notice at least 15 calendar days before the adverse action's effective date. The notice shall state (1) the factual basis for the agency's determination, (2) the action the agency intends to take, (3) the dollar amount of the monetary recovery or recoupment, if known, and (4) the provider's right to appeal the agency's proposed action.

(c) The provider may appeal an administrative disqualification by submitting a written request to the state agency. A provider's request must be received by the state agency no later than 30 days after the date the commissioner mails the notice.

(d) The provider's appeal request must contain the following:

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

(2) the computation the provider believes to be correct, if applicable;

(3) the statute or rule relied on for each disputed item; and

(4) the name, address, and telephone number of the person at the provider's place of business with whom contact may be made regarding the appeal.

(e) On appeal, the issuing agency bears the burden of proof to demonstrate by a preponderance of the evidence that the provider committed an intentional program violation.

(f) The hearing is subject to the requirements of section 142A.20. The human services judge may combine a fair hearing and administrative disqualification hearing into a single hearing if the factual issues arise out of the same or related circumstances and the provider receives prior notice that the hearings will be combined.

(g) A provider found to have committed an intentional program violation and is administratively disqualified must be disqualified, for a period of three years for the first offense and permanently for any subsequent offense, from receiving any payments from any child care program under this chapter.

(h) Unless a timely and proper appeal made under this section is received by the department, the administrative determination of the department is final and binding.

Sec. 2. Minnesota Statutes 2024, section 142E.51, subdivision 6, is amended to read:

Subd. 6. **Prohibited hiring ~~practice~~ practices.** ~~It is prohibited to~~ A person must not hire a child care center employee when, as a condition of employment, the employee is required to have one or more children who are eligible for or receive child care assistance, if:

(1) the individual hiring the employee is, or is acting at the direction of or in cooperation with, a child care center provider, center owner, director, manager, license holder, or other controlling individual; and

(2) the individual hiring the employee knows or has reason to know the purpose in hiring the employee is to obtain child care assistance program funds.

Sec. 3. Minnesota Statutes 2024, section 142E.51, is amended by adding a subdivision to read:

Subd. 6a. **Illegal remuneration.** (a) Except as provided in paragraph (b), program applicants, participants, and providers must not offer, provide, solicit, or receive money, a discount, a credit, a waiver, a rebate, a good, a service, employment, or anything else of value in exchange for:

(1) obtaining or attempting to obtain child care assistance program benefits; or

(2) directing a person's child care assistance program benefits to a particular provider.

(b) The prohibition in paragraph (a) does not apply to:

(1) marketing or promotional offerings that directly benefit an applicant or recipient's child or dependent for whom the child care provider is providing child care services; or

(2) child care provider discounts, scholarships, or other financial assistance allowed under section 142E.17, subdivision 7.

(c) An attempt to buy or sell access to a family's child care assistance program benefits to an unauthorized person by an applicant, a participant, or a provider is an intentional program violation under subdivision 5 and wrongfully obtaining assistance under section 256.98.

Sec. 4. Minnesota Statutes 2024, section 144.651, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for the purpose of diagnosis or treatment bearing on the physical or mental health of that person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a person who receives health care services at an outpatient surgical center or at a birth center licensed under section 144.615. "Patient" also means a ~~minor~~ person who is admitted to a residential program as defined in section 253C.01. "Patient" also means a person who is admitted to a residential substance use disorder treatment program licensed according to Minnesota Rules, parts 2960.0430 to 2960.0490. For purposes of subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving mental health treatment or substance use disorder treatment on an outpatient basis or in a community support program or other community-based program. "Resident" means a person who is admitted to a nonacute care facility including extended care facilities, nursing homes, and boarding care homes for care required because of prolonged mental or physical illness or disability, recovery from injury or disease, or advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and ~~which~~ that operates a ~~rehabilitation~~ withdrawal management program licensed under chapter 245F, a residential substance use disorder treatment program licensed under chapter 245G ~~or~~, an intensive residential treatment services or residential crisis stabilization program licensed under chapter 245I, or a detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590.

Sec. 5. Minnesota Statutes 2024, section 245A.04, subdivision 1, 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.

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.

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.043.

(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.

Sec. 6. Minnesota Statutes 2024, 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;

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

(6) any special conditions of licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of a controlling individual or license holder, and the controlling individual or license holder is ordered under section 245C.17 to be immediately removed from direct contact with persons receiving services or is ordered to be under

continuous, direct supervision when providing direct contact services, the program may continue to operate only if the program complies with the order and submits documentation demonstrating compliance with the order. If the disqualified individual fails to submit a timely request for reconsideration, or if the disqualification is not set aside and no variance is granted, the order to immediately remove the individual from direct contact or to be under continuous, direct supervision remains in effect pending the outcome of a hearing and final order from the commissioner.

(k) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must ~~apply for and be granted~~ 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.

Sec. 7. Minnesota Statutes 2024, section 245A.16, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies that have been designated by the commissioner to perform licensing functions and activities under section 245A.04; to recommend denial of applicants under section 245A.05; to issue correction orders, to issue variances, and recommend a conditional license under section 245A.06; or to recommend suspending or revoking a license or issuing a fine under section 245A.07, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of child foster residence setting and community residential setting;

(2) until the responsibility for family child foster care transfers to the commissioner of children, youth, and families under Laws 2023, chapter 70, article 12, section 30, dual licensure of family child foster care and family adult foster care;

(3) until the responsibility for family child care transfers to the commissioner of children, youth, and families under Laws 2023, chapter 70, article 12, section 30, dual licensure of family adult foster care and family child care;

(4) adult foster care or community residential setting maximum capacity;

(5) adult foster care or community residential setting minimum age requirement;

(6) child foster care maximum age requirement;

(7) variances regarding disqualified individuals;

(8) the required presence of a caregiver in the adult foster care residence during normal sleeping hours;

(9) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder; and

(10) variances to section 142B.46 for the use of a cradleboard for a cultural accommodation.

(b) Once the respective responsibilities transfer from the commissioner of human services to the commissioner of children, youth, and families, under Laws 2023, chapter 70, article 12, section 30, the commissioners of human services and children, youth, and families must both approve a variance for dual licensure of family child foster care and family adult foster care or family adult foster care and family child care. Variances under this paragraph are excluded from the delegation of variance authority and may be issued only by both commissioners.

~~(c) For family adult day services programs, the commissioner may authorize licensing reviews every two years after a licensee has had at least one annual review.~~

~~(d) A~~ (c) An adult foster care, family adult day services, child foster residence setting, or community residential services license issued under this section may be issued for up to two years until implementation of the provider licensing and reporting hub. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

~~(e)~~ (d) During implementation of chapter 245D, the commissioner shall consider:

(1) the role of counties in quality assurance;

(2) the duties of county licensing staff; and

(3) the possible use of joint powers agreements, according to section 471.59, with counties through which some licensing duties under chapter 245D may be delegated by the commissioner to the counties.

Any consideration related to this paragraph must meet all of the requirements of the corrective action plan ordered by the federal Centers for Medicare and Medicaid Services.

~~(f)~~ (e) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or successor provisions; and section 245D.061 or successor provisions, for family child foster care programs providing out-of-home respite, as identified in section 245D.03, subdivision 1, paragraph (b), clause (1), is excluded from the delegation of authority to county agencies.

Sec. 8. Minnesota Statutes 2024, 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 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 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. 9. Minnesota Statutes 2024, section 245C.05, is amended by adding a subdivision to read:

Subd. 9. **Electronic signature.** For documentation requiring a signature under this chapter, use of an electronic signature as defined under section 325L.02, paragraph (h), is allowed.

Sec. 10. Minnesota Statutes 2024, section 245C.08, subdivision 3, is amended to read:

Subd. 3. **Arrest and investigative information.** (a) For any background study completed under this section, if the commissioner has reasonable cause to believe the information is pertinent to the disqualification of an individual, the commissioner also may review arrest and investigative information from:

(1) the Bureau of Criminal Apprehension;

(2) the commissioners of children, youth, and families; health; and human services;

(3) a ~~county attorney~~ prosecutor;

~~(4) a county sheriff;~~

~~(5)~~ (4) a county agency;

~~(6)~~ (5) a ~~local chief of police~~ law enforcement agency;

~~(7)~~ (6) other states;

~~(8)~~ (7) the courts;

~~(9)~~ (8) the Federal Bureau of Investigation;

~~(10)~~ (9) the National Criminal Records Repository; and

~~(11)~~ (10) criminal records from other states.

(b) Except when specifically required by law, the commissioner is not required to conduct more than one review of a subject's records from the Federal Bureau of Investigation if a review of the subject's criminal history with the Federal Bureau of Investigation has already been completed by the commissioner and there has been no break in the subject's affiliation with the entity that initiated the background study.

(c) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the data obtained is private data and cannot be shared with private agencies or prospective employers of the background study subject.

(d) If the commissioner conducts a national criminal history record check when required by law and uses the information from the national criminal history record check to make a disqualification determination, the license holder or entity that submitted the study is not required to obtain a copy of the background study subject's disqualification letter under section 245C.17, subdivision 3.

Sec. 11. Minnesota Statutes 2024, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23. For personal care provider organizations, financial management services organizations, community first services and supports organizations, unlicensed home and community-based organizations, and consumer-directed community supports organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04, subdivision 1, paragraph (h), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the substance use disorder field, if the commissioner has previously set aside an individual's disqualification for one or more programs or agencies in the substance use disorder treatment field, and the individual is the subject of a subsequent background study for a different program or agency in the substance use disorder treatment field, the commissioner shall set aside the disqualification for the program or agency in the substance use disorder treatment field that initiated the subsequent background study when the criteria under paragraph (b), clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified in section 245C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued within 15 working days.

(d) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

Sec. 12. Minnesota Statutes 2024, section 245D.02, subdivision 4a, is amended to read:

Subd. 4a. **Community residential setting.** "Community residential setting" means a residential program ~~as identified in section 245A.11, subdivision 8,~~ where residential supports and services identified in section 245D.03, subdivision 1, paragraph (c), clause (3), items (i) and (ii), are provided to adults, as defined in section 245A.02, subdivision 2, and the license holder is the owner, lessor, or tenant of the facility licensed according to this chapter, and the license holder does not reside in the facility.

EFFECTIVE DATE. This section is effective August 1, 2025.

Sec. 13. Minnesota Statutes 2024, section 245G.05, subdivision 1, is amended to read:

Subdivision 1. **Comprehensive assessment.** A comprehensive assessment of the client's substance use disorder must be administered face-to-face by an alcohol and drug counselor within five calendar days from the day of service initiation for a residential program or by the end of the fifth day on which a treatment service is provided in a nonresidential program. The number of days to complete the comprehensive assessment excludes the day of service initiation. If the comprehensive assessment is not completed within the required time frame, the person-centered reason for the delay and the planned completion date must be documented in the client's file. The comprehensive assessment is complete upon a qualified staff member's dated signature. If the client previously received a comprehensive assessment ~~that authorized the treatment service~~, an alcohol and drug counselor may use the comprehensive assessment for requirements of this subdivision but must document a review of the comprehensive assessment and update the comprehensive assessment as clinically necessary to ensure compliance with this subdivision within applicable timelines. An alcohol and drug counselor must sign and date the comprehensive assessment review and update.

Sec. 14. Minnesota Statutes 2024, section 245G.06, subdivision 1, is amended to read:

Subdivision 1. **General.** Each client must have a person-centered individual treatment plan developed by an alcohol and drug counselor within ten days from the day of service initiation for a residential program, by the end of the tenth day on which a treatment session has been provided from the day of service initiation for a client in a nonresidential program, not to exceed 30 days. Opioid treatment programs must complete the individual treatment plan within ~~21~~ 14 days from the day of service initiation. The number of days to complete the individual treatment plan excludes the day of service initiation. The individual treatment plan must be signed by the client and the alcohol and drug counselor and document the client's involvement in the development of the plan. The individual treatment plan is developed upon the qualified staff member's dated signature. Treatment planning must include ongoing assessment of client needs. An individual treatment plan must be updated based on new information gathered about the client's condition, the client's level of participation, and on whether methods identified have the intended effect. A change to the plan must be signed by the client and the alcohol and drug counselor. If the client chooses to have family or others involved in treatment services, the client's individual treatment plan must include how the family or others will be involved in the client's treatment. If a client is receiving treatment services or an assessment via telehealth and the alcohol and drug counselor documents the reason the client's signature cannot be obtained, the alcohol and drug counselor may document the client's verbal approval or electronic written approval of the treatment plan or change to the treatment plan in lieu of the client's signature.

Sec. 15. Minnesota Statutes 2024, section 245G.06, subdivision 2a, is amended to read:

Subd. 2a. **Documentation of treatment services.** The license holder must ensure that the staff member who provides the treatment service documents in the client record the date, type, and amount of each treatment

service provided to a client and the client's response to each treatment service within seven days of providing the treatment service. In addition to the other requirements of this subdivision, if a guest speaker presents information during a treatment service, the alcohol and drug counselor who provided the service and is responsible for the information presented by the guest speaker must document the name of the guest speaker, date of service, time the presentation began, time the presentation ended, and a summary of the topic presentation.

Sec. 16. Minnesota Statutes 2024, section 245G.06, subdivision 3a, is amended to read:

Subd. 3a. **Frequency of treatment plan reviews.** (a) A license holder must ensure that the alcohol and drug counselor responsible for a client's treatment plan completes and documents a treatment plan review that meets the requirements of subdivision 3 in each client's file, according to the frequencies required in this subdivision. All ASAM levels referred to in this chapter are those described in section 254B.19, subdivision 1.

(b) For a client receiving residential ASAM level 3.3 or 3.5 high-intensity services or residential hospital-based services, a treatment plan review must be completed once every 14 days.

(c) For a client receiving residential ASAM level 3.1 low-intensity services or any other residential level not listed in paragraph (b), a treatment plan review must be completed once every 30 days.

(d) For a client receiving nonresidential ASAM level 2.5 partial hospitalization services, a treatment plan review must be completed once every 14 days.

(e) For a client receiving nonresidential ASAM level 1.0 outpatient or 2.1 intensive outpatient services or any other nonresidential level not included in paragraph (d), a treatment plan review must be completed once every 30 days.

(f) For a client receiving nonresidential opioid treatment program services according to section 245G.22, a treatment plan review must be completed:

(1) weekly for the ten weeks following completion of the treatment plan; and

(2) monthly thereafter.

Treatment plan reviews must be completed more frequently when clinical needs warrant.

(g) The ten-week time frame in paragraph (f), clause (1), may include a client's previous time at another opioid treatment program licensed in Minnesota under section 245G.22 if:

(1) the client was enrolled in the other opioid treatment program immediately prior to admission to the license holder's program;

(2) the client did not miss taking a daily dose of medication to treat an opioid use disorder; and

(3) the license holder obtains from the previous opioid treatment program the client's number of days in comprehensive treatment, discharge summary, amount of daily milligram dose of medication for opioid use disorder, and previous three drug abuse test results.

~~(g)~~ (h) Notwithstanding paragraphs (e) and (f), clause (2), for a client in a nonresidential program with a treatment plan that clearly indicates less than five hours of skilled treatment services will be provided to the client each month, a treatment plan review must be completed once every 90 days. Treatment plan reviews must be completed more frequently when clinical needs warrant.

Sec. 17. Minnesota Statutes 2024, section 245G.07, subdivision 2, is amended to read:

Subd. 2. **Additional treatment service.** A license holder may provide or arrange the following additional treatment service as a part of the client's individual treatment plan:

(1) relationship counseling provided by a qualified professional to help the client identify the impact of the client's substance use disorder on others and to help the client and persons in the client's support structure identify and change behaviors that contribute to the client's substance use disorder;

(2) therapeutic recreation to allow the client to participate in recreational activities without the use of mood-altering chemicals and to plan and select leisure activities that do not involve the inappropriate use of chemicals;

(3) stress management and physical well-being to help the client reach and maintain an appropriate level of health, physical fitness, and well-being;

(4) living skills development to help the client learn basic skills necessary for independent living;

(5) employment or educational services to help the client become financially independent;

(6) socialization skills development to help the client live and interact with others in a positive and productive manner;

(7) room, board, and supervision at the treatment site to provide the client with a safe and appropriate environment to gain and practice new skills; and

(8) peer recovery support services must be provided one-to-one and face-to-face, by a recovery peer ~~qualified~~ according to section 245I.04, subdivision 18. Peer recovery support services must be provided according to sections 254B.05, subdivision 5, and 254B.052, and may be provided through telehealth according to section 256B.0625, subdivision 3b.

Sec. 18. Minnesota Statutes 2024, section 245G.08, subdivision 6, is amended to read:

Subd. 6. **Control of drugs.** A license holder must have and implement written policies and procedures developed by a registered nurse that contain:

(1) a requirement that each drug must be stored in a locked compartment. A Schedule II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked compartment, permanently affixed to the physical plant or medication cart;

(2) a documentation system ~~which~~ that accounts for all ~~scheduled drugs each shift~~ schedule II to V drugs listed in section 152.02, subdivisions 3 to 6;

(3) a procedure for recording the client's use of medication, including the signature of the staff member who completed the administration of the medication with the time and date;

(4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

(5) a statement that only authorized personnel are permitted access to the keys to a locked compartment;

(6) a statement that no legend drug supply for one client shall be given to another client; and

(7) a procedure for monitoring the available supply of an opiate antagonist as defined in section 604A.04, subdivision 1, on site and replenishing the supply when needed.

Sec. 19. Minnesota Statutes 2024, section 245G.09, subdivision 3, is amended to read:

Subd. 3. **Contents.** (a) Client records must contain the following:

(1) documentation that the client was given:

(i) information on client rights and responsibilities~~,~~ and grievance procedures~~,~~ on the day of service initiation;

(ii) information on tuberculosis~~,~~ and HIV~~, and that the client was provided~~ within 72 hours of service initiation;

(iii) an orientation to the program abuse prevention plan required under section 245A.65, subdivision 2, paragraph (a), clause (4)~~. If the client has an opioid use disorder, the record must contain documentation that the client was provided~~, within 24 hours of admission or, for clients who would benefit from a later orientation, 72 hours; and

(iv) opioid educational ~~information~~ material according to section 245G.04, subdivision 3, on the day of service initiation;

(2) an initial services plan completed according to section 245G.04;

(3) a comprehensive assessment completed according to section 245G.05;

(4) an individual abuse prevention plan according to sections 245A.65, subdivision 2, and 626.557, subdivision 14, when applicable;

(5) an individual treatment plan according to section 245G.06, subdivisions 1 and 1a;

(6) documentation of treatment services, significant events, appointments, concerns, and treatment plan reviews according to section 245G.06, subdivisions 2a, 2b, 3, and 3a; and

(7) a summary at the time of service termination according to section 245G.06, subdivision 4.

(b) For a client that transfers to another of the license holder's licensed treatment locations, the license holder is not required to complete new documents or orientation for the client, except that the client must receive an orientation to the new location's grievance procedure, program abuse prevention plan, and maltreatment of minor and vulnerable adults reporting procedures.

Sec. 20. Minnesota Statutes 2024, section 245G.11, subdivision 11, is amended to read:

Subd. 11. **Individuals with temporary permit.** An individual with a temporary permit from the Board of Behavioral Health and Therapy may provide substance use disorder treatment ~~service~~ services and complete comprehensive assessments, individual treatment plans, treatment plan reviews, and service discharge summaries according to this subdivision if they meet the requirements of either paragraph (a) or (b).

(a) An individual with a temporary permit must be supervised by a licensed alcohol and drug counselor assigned by the license holder. The supervising licensed alcohol and drug counselor must document the amount and type of supervision provided at least on a weekly basis. The supervision must relate to the clinical practice.

(b) An individual with a temporary permit must be supervised by a clinical supervisor approved by the Board of Behavioral Health and Therapy. The supervision must be documented and meet the requirements of section 148F.04, subdivision 4.

Sec. 21. Minnesota Statutes 2024, section 245G.18, subdivision 2, is amended to read:

Subd. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements specified in section 245G.11, subdivisions 1 and 5, an alcohol and drug counselor providing treatment service to an adolescent must have~~:~~

~~(1)~~ an additional 30 hours of training or classroom instruction or one three-credit semester college course in adolescent development. ~~This~~ The training, classroom instruction, or college course must be completed no later than six months after the counselor first provides treatment services to adolescents and need only be completed one time~~; and~~. The training must be interactive and must not consist only of reading information. An alcohol and drug counselor who is also qualified as a mental health professional under section 245I.04, subdivision 2, is exempt from the requirement in this subdivision.

~~(2) at least 150 hours of supervised experience as an adolescent counselor, either as a student or as a staff member.~~

Sec. 22. Minnesota Statutes 2024, section 245G.19, subdivision 4, is amended to read:

Subd. 4. **Additional licensing requirements.** During the times the license holder is responsible for the supervision of a child, except for license holders described in subdivision 5, the license holder must meet the following standards:

(1) child and adult ratios in Minnesota Rules, part 9502.0367;

(2) day care training in section 142B.70;

(3) behavior guidance in Minnesota Rules, part 9502.0395;

(4) activities and equipment in Minnesota Rules, part 9502.0415;

(5) physical environment in Minnesota Rules, part 9502.0425;

(6) physical space requirements in section 142B.72; and

(7) water, food, and nutrition in Minnesota Rules, part 9502.0445, unless the license holder has a license from the Department of Health.

Sec. 23. Minnesota Statutes 2024, section 245G.19, is amended by adding a subdivision to read:

Subd. 5. **Child care license exemption.** (a) License holders that only provide supervision of children for less than three hours a day while the child's parent is in the same building or contiguous building as allowed by the exclusion from licensure in section 245A.03, subdivision 2, paragraph (a), clause (6), are exempt from the requirements of subdivision 4 if the requirements of this subdivision are met.

(b) During the times the license holder is responsible for the supervision of the child, there must always be a staff member present who is responsible for supervising the child who is trained in cardiopulmonary resuscitation (CPR) and first aid. This staff person must be able to immediately contact the child's parent at all times.

Sec. 24. Minnesota Statutes 2024, section 245G.22, subdivision 1, is amended to read:

Subdivision 1. **Additional requirements.** (a) An opioid treatment program licensed under this chapter must also: (1) comply with the requirements of this section and Code of Federal Regulations, title 42, part

8; (2) be registered as a narcotic treatment program with the Drug Enforcement Administration; (3) be accredited through an accreditation body approved by the Division of Pharmacologic Therapy of the Center for Substance Abuse Treatment; (4) be certified through the Division of Pharmacologic Therapy of the Center for Substance Abuse Treatment; and (5) hold a license from the Minnesota Board of Pharmacy or ~~equivalent agency~~ meet the requirements for dispensing by a practitioner in section 151.37, subdivision 2, and Minnesota Rules, parts 6800.9950 to 6800.9954.

(b) A license holder operating under the dispensing by practitioner requirements in section 151.37, subdivision 2, and Minnesota Rules, parts 6800.9950 to 6800.9954, must maintain documentation that the practitioner responsible for complying with the above statute and rules has signed a statement attesting that they are the practitioner responsible for complying with the applicable statutes and rules. If more than one person is responsible for compliance, all practitioners must sign a statement.

~~(b)~~ (c) Where a standard in this section differs from a standard in an otherwise applicable administrative rule or statute, the standard of this section applies.

Sec. 25. Minnesota Statutes 2024, section 245G.22, subdivision 14, is amended to read:

Subd. 14. **Central registry.** ~~(a)~~ A license holder must comply with requirements to submit information and necessary consents to the state central registry for each client admitted, as specified by the commissioner. The license holder must submit data concerning medication used for the treatment of opioid use disorder. The data must be submitted in a method determined by the commissioner and the original information must be kept in the client's record. The information must be submitted for each client at admission and discharge. The program must document the date the information was submitted. The client's failure to provide the information shall prohibit participation in an opioid treatment program. The information submitted must include the client's:

(1) full name and all aliases;

(2) date of admission;

(3) date of birth;

(4) Social Security number or Alien Registration Number, if any; and

(5) current or previous enrollment status in another opioid treatment program~~;~~.

~~(6) government-issued photo identification card number; and~~

~~(7) driver's license number, if any.~~

~~(b) The requirements in paragraph (a) are effective upon the commissioner's implementation of changes to the drug and alcohol abuse normative evaluation system or development of an electronic system by which to submit the data.~~

Sec. 26. Minnesota Statutes 2024, section 245G.22, subdivision 15, is amended to read:

Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must offer at least 50 consecutive minutes of individual or group therapy treatment services as defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first ten weeks following the day of service initiation, and at least 50 consecutive minutes per month thereafter. As clinically appropriate, the program may offer these services cumulatively and not consecutively in increments of no less than 15 minutes over

the required time period, and for a total of 60 minutes of treatment services over the time period, and must document the reason for providing services cumulatively in the client's record. The program may offer additional levels of service when deemed clinically necessary.

(b) The ten-week time frame may include a client's previous time at another opioid treatment program licensed in Minnesota under this section if:

(1) the client was enrolled in the other opioid treatment program immediately prior to admission to the license holder's program;

(2) the client did not miss taking a daily dose of medication to treat an opioid use disorder; and

(3) the license holder obtains from the previous opioid treatment program the client's number of days in comprehensive maintenance treatment, discharge summary, amount of daily milligram dose of medication for opioid use disorder, and previous three drug abuse test results.

~~(b)~~ (c) Notwithstanding the requirements of comprehensive assessments in section 245G.05, the assessment must be completed within 21 days from the day of service initiation.

Sec. 27. Minnesota Statutes 2024, section 256.98, subdivision 1, is amended to read:

Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897, the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program formerly codified in sections 256.72 to 256.871, chapter 142G, 256B, 256D, 256I, 256K, or 256L, child care assistance programs, and emergency assistance programs under section 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses (1) to (5):

(1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a willfully false statement or representation, by intentional concealment of any material fact, or by impersonation or other fraudulent device, assistance or the continued receipt of assistance, to include child care assistance or food benefits produced according to sections 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94, and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that to which the person is entitled;

(2) knowingly aids or abets in buying or in any way disposing of the property of a recipient or applicant of assistance without the consent of the county agency; or

(3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments to which the individual is not entitled as a provider of subsidized child care~~, or~~; by ~~furnishing or concurring in~~ offering, providing, soliciting, or receiving illegal remuneration as described in section 142E.51, subdivision 6a, or in violation of section 609.542, subdivision 2; or by submitting or aiding and abetting the submission of a willfully false claim for child care assistance.

(b) The continued receipt of assistance to which the person is not entitled or greater than that to which the person is entitled as a result of any of the acts, failure to act, or concealment described in this subdivision shall be deemed to be continuing offenses from the date that the first act or failure to act occurred.

Sec. 28. Minnesota Statutes 2024, section 256B.064, subdivision 1a, is amended to read:

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

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

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

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

(4) suspension or termination as a Medicare vendor;

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

(6) failure to repay an overpayment or a fine finally established under this section;

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

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

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

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

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

Sec. 29. Minnesota Statutes 2024, section 256B.092, subdivision 11, is amended to read:

Subd. 11. **Residential support services.** (a) Upon federal approval, there is established a new service called residential support that is available on the community alternative care, community access for disability inclusion, developmental disabilities, and brain injury waivers. Existing waiver service descriptions must be modified to the extent necessary to ensure there is no duplication between other services. Residential support services must be provided by vendors licensed as a community residential setting ~~as defined in section 245A.11, subdivision 8~~, a foster care setting licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, or an adult foster care setting licensed under Minnesota Rules, parts 9555.5105 to 9555.6265.

(b) Residential support services must meet the following criteria:

(1) the residential site must have a designated person responsible for program management, oversight, development, and implementation of policies and procedures;

(2) the provider of residential support services must provide supervision, training, and assistance as described in the person's support plan; and

(3) the provider of residential support services must meet the requirements of licensure and additional requirements of the person's support plan.

(c) Providers of residential support services that meet the definition in paragraph (a) must be licensed according to chapter 245D. Providers licensed to provide child foster care under Minnesota Rules, parts 2960.3000 to 2960.3340, or adult foster care licensed under Minnesota Rules, parts 9555.5105 to 9555.6265, and that meet the requirements in section 245A.03, subdivision 7, paragraph (f), are considered registered under this section.

Sec. 30. Minnesota Statutes 2024, section 256B.12, is amended to read:

256B.12 LEGAL REPRESENTATION.

The attorney general or the appropriate county attorney appearing at the direction of the attorney general shall be the attorney for the state agency, and the county attorney of the appropriate county shall be the attorney for the ~~local~~ county agency in all matters pertaining hereto. To prosecute under this chapter or sections 609.466 ~~and~~, 609.52, subdivision 2~~,~~; and 609.542 or to recover payments wrongfully made under this chapter, the attorney general or the appropriate county attorney, acting independently or at the direction of the attorney general may institute a criminal or civil action.

Sec. 31. Minnesota Statutes 2024, section 256I.04, subdivision 2c, is amended to read:

Subd. 2c. **Background study requirements.** (a) ~~Effective July 1, 2016,~~ A provider of housing support must initiate background studies in accordance with ~~chapter 245C of the following individuals:~~ section 245C.03, subdivision 10.

~~(1) controlling individuals as defined in section 245A.02;~~

~~(2) managerial officials as defined in section 245A.02; and~~

~~(3) all employees and volunteers of the establishment who have direct contact with recipients, or who have unsupervised access to recipients, their personal property, or their private data.~~

(b) ~~The provider of housing support must maintain compliance with all requirements established for entities initiating background studies under chapter 245C~~ A provider initiating a background study pursuant to chapter 245C is not required to initiate a background study in accordance with sections 299C.66 to 299C.71 or chapter 364.

~~(c) Effective July 1, 2017, a provider of housing support must demonstrate that all individuals required to have a background study according to paragraph (a) have a notice stating either that:~~

~~(1) the individual is not disqualified under section 245C.14; or~~

~~(2) the individual is disqualified, but the individual has been issued a set-aside of the disqualification for that setting under section 245C.22.~~

Sec. 32. **[609.542] ILLEGAL REMUNERATIONS.**

Subdivision 1. **Definition.** For purposes of this section, "federal health care program" has the meaning given in United States Code, title 42, section 1320a-7b(f).

Subd. 2. **Human services program; unauthorized remuneration.** (a) A person who intentionally solicits or receives money, a discount, a credit, a waiver, a rebate, a good, a service, employment, or anything else of value in return for doing any of the following is guilty of a crime and may be sentenced as provided in subdivision 4:

(1) referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program, behavioral health program under chapter 254B, or program under chapter 142E;

(2) purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a federal health care program, behavioral health program under chapter 254B, or program under chapter 142E; or

(3) applying for or receiving any item or service for which payment may be made in whole or in part under a federal health care program, behavioral health program under chapter 254B, or program under chapter 142E.

(b) A person who intentionally offers or provides money, a discount, a credit, a waiver, a rebate, a good, a service, employment, or anything else of value to induce a person to do any of the following is guilty of a crime and may be sentenced as provided in subdivision 4:

(1) refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a federal health care program, behavioral health program under chapter 254B, or program under chapter 142E;

(2) purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a federal health care program, behavioral health program under chapter 254B, or program under chapter 142E; or

(3) apply for or receive any item or service for which payment may be made in whole or in part under a federal health care program, behavioral health program under chapter 254B, or program under chapter 142E.

Subd. 3. **Exceptions.** (a) Subdivision 2 does not apply to any payment, discount, waiver, or other remuneration exempted under United States Code, title 42, section 1320a-7b(b)(3), or payment made under a federal health care program that is exempt from liability by United States Code, title 42, section 1001.952.

(b) For actions involving a program under chapter 142E, subdivision 2 does not apply to:

(1) any amount paid by an employer to a bona fide employee for providing covered items or services under chapter 142E while acting in the course and scope of employment; or

(2) child care provider discounts, scholarships, or other financial assistance to families allowed under section 142E.17, subdivision 7.

Subd. 4. **Penalties.** An individual who violates subdivision 2 may be sentenced as follows:

(1) imprisonment of not more than 20 years or payment of a fine of not more than $100,000, or both, if the value of any money, discount, credit, waiver, rebate, good, service, employment, or other thing of value solicited, received, offered, or provided exceeds $35,000;

(2) imprisonment of not more than ten years or payment of a fine of not more than $20,000, or both, if the value of any money, discount, credit, waiver, rebate, good, service, employment, or other item of value solicited, received, offered, or provided is more than $5,000 but not more than $35,000; or

(3) imprisonment for not more than five years or payment of a fine of not more than $10,000, or both, if the value of any money, discount, credit, waiver, rebate, good, service, employment, or other item of value solicited, received, offered, or provided is not more than $5,000.

Subd. 5. **Aggregation.** In a prosecution under this section, the value of any money, discount, credit, waiver, rebate, good, service, employment, or other item of value solicited, received, offered, or provided within a six-month period may be aggregated and the defendant charged accordingly. When two or more offenses are committed by the same person in two or more counties, the accused may be prosecuted in any county in which one of the offenses was committed for all of the offenses aggregated under this subdivision.

Subd. 6. **False claims.** In addition to the penalties provided in this section, a claim, as defined in section 15C.01, subdivision 2, that includes items or services resulting from a violation of this section constitutes a false or fraudulent claim for purposes of section 15C.02.

EFFECTIVE DATE. This section is effective August 1, 2025, and applies to crimes committed on or after that date.

Sec. 33. Laws 2023, chapter 70, article 7, section 34, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~for background studies requested on or after August 1, 2024~~ the day following final enactment.

Sec. 34. **REPEALER.**

(a) Minnesota Statutes 2024, section 245A.11, subdivision 8, is repealed.

(b) Minnesota Statutes 2024, section 245A.042, subdivisions 2, 3, and 4, are repealed.

EFFECTIVE DATE. Paragraph (a) is effective August 1, 2025.

ARTICLE 6

ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES RECODIFICATION

Section 1. Minnesota Statutes 2024, section 256B.0622, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, assertive community treatment when the services are provided by an entity certified under and meeting the standards in this section.

~~(b) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.~~

~~(c)~~ (b) 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. 2. Minnesota Statutes 2024, section 256B.0622, subdivision 8, is amended to read:

Subd. 8. **Medical assistance payment for assertive community treatment ~~and intensive residential treatment~~ services.** (a) Payment for ~~intensive residential treatment services and~~ assertive community treatment in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (d), payment will not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) ~~Payment must not be made based solely on a court order to participate in intensive residential treatment services. If a client has a court order to participate in the program or to obtain assessment for treatment and follow treatment recommendations,~~ Payment under this section must only be provided if the client is eligible for the service and the service is determined to be medically necessary.

(d) The commissioner shall determine ~~one rate for each provider that will bill medical assistance for residential services under this section and~~ one rate for each assertive community treatment provider under this section. If a single entity provides both ~~services~~ intensive residential treatment services under section 256B.0632 and assertive community treatment under this section, one rate is established for the entity's intensive residential treatment services under section 256B.0632 and another rate for the entity's ~~nonresidential~~ assertive community treatment services under this section. A provider is not eligible for payment under this section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

(1) the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

(i) the direct services costs must be determined using actual costs of salaries, benefits, payroll taxes, and training of direct service staff and service-related transportation;

(ii) other program costs not included in item (i) must be determined as a specified percentage of the direct services costs as determined by item (i). The percentage used shall be determined by the commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provide similar services;

(iii) physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space;

(iv) assertive community treatment physical plant costs must be reimbursed as part of the costs described in item (ii); and

(v) subject to federal approval, up to an additional five percent of the total rate may be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

(2) actual ~~cost is~~ costs are defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget ~~Circular Number A-122~~ Uniform Guidance under Code of Federal Regulations, title 2, section 200, relating to nonprofit entities;

(3) the number of service units;

(4) the degree to which clients will receive services other than services under this section or section 256B.0632; and

(5) the costs of other services that will be separately reimbursed.

(e) The rate for ~~intensive residential treatment services and~~ assertive community treatment must exclude the medical assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

~~(f) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist, or other health care professional providing physician services within their scope of practice, is a member of the intensive residential treatment services treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth is used to provide intensive residential treatment services.~~

~~(g)~~ (f) When services under this section are provided by an assertive community treatment provider, case management functions must be an integral part of the team.

~~(h)~~ (g) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

~~(i)~~ (h) The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (d). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (d).

~~(j)~~ (i) Effective for the rate years beginning on and after January 1, 2024, rates for assertive community treatment, adult residential crisis stabilization services, and intensive residential treatment services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined. This paragraph expires upon federal approval.

(j) Effective upon the expiration of paragraph (i), and effective for the rate years beginning on and after January 1, 2024, rates for assertive community treatment services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(k) Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed

costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner and must reflect a difference of greater than five percent.

(l) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

Sec. 3. Minnesota Statutes 2024, section 256B.0622, subdivision 11, is amended to read:

Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds directly to ~~intensive residential treatment services providers and~~ assertive community treatment providers to maintain access to these services.

Sec. 4. Minnesota Statutes 2024, section 256B.0622, subdivision 12, is amended to read:

Subd. 12. **Start-up grants.** The commissioner may, within available appropriations, disburse grant funding to counties, Indian tribes, or mental health service providers to establish additional assertive community treatment teams~~, intensive residential treatment services, or crisis residential services~~.

Sec. 5. **[256B.0632] INTENSIVE RESIDENTIAL TREATMENT SERVICES.**

Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically necessary, intensive residential treatment services when the services are provided by an entity licensed under and meeting the standards in section 245I.23.

(b) 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.

Subd. 2. **Provider entity licensure and contract requirements for intensive residential treatment services.** (a) The commissioner shall develop procedures for counties and providers to submit other documentation as needed to allow the commissioner to determine whether the standards in this section are met.

(b) A provider entity must specify in the provider entity's application what geographic area and populations will be served by the proposed program. A provider entity must document that the capacity or program specialties of existing programs are not sufficient to meet the service needs of the target population. A provider entity must submit evidence of ongoing relationships with other providers and levels of care to facilitate referrals to and from the proposed program.

(c) A provider entity must submit documentation that the provider entity requested a statement of need from each county board and Tribal authority that serves as a local mental health authority in the proposed service area. The statement of need must specify if the local mental health authority supports or does not support the need for the proposed program and the basis for this determination. If a local mental health authority does not respond within 60 days of the receipt of the request, the commissioner shall determine the need for the program based on the documentation submitted by the provider entity.

Subd. 3. **Medical assistance payment for intensive residential treatment services.** (a) Payment for intensive residential treatment services in this section shall be based on one daily rate per provider inclusive of the following services received by an eligible client in a given calendar day: all rehabilitative services

under this section, staff travel time to provide rehabilitative services under this section, and nonresidential crisis stabilization services under section 256B.0624.

(b) Except as indicated in paragraph (d), payment will not be made to more than one entity for each client for services provided under this section on a given day. If services under this section are provided by a team that includes staff from more than one entity, the team must determine how to distribute the payment among the members.

(c) Payment must not be made based solely on a court order to participate in intensive residential treatment services. If a client has a court order to participate in the program or to obtain assessment for treatment and follow treatment recommendations, payment under this section must only be provided if the client is eligible for the service and the service is determined to be medically necessary.

(d) The commissioner shall determine one rate for each provider that will bill medical assistance for intensive residential treatment services under this section. If a single entity provides both intensive residential treatment services under this section and assertive community treatment under section 256B.0622, one rate is established for the entity's intensive residential treatment services under this section and another rate for the entity's assertive community treatment services under section 256B.0622. A provider is not eligible for payment under this section without authorization from the commissioner. The commissioner shall develop rates using the following criteria:

(1) the provider's cost for services shall include direct services costs, other program costs, and other costs determined as follows:

(i) the direct services costs must be determined using actual costs of salaries, benefits, payroll taxes, and training of direct service staff and service-related transportation;

(ii) other program costs not included in item (i) must be determined as a specified percentage of the direct services costs as determined by item (i). The percentage used shall be determined by the commissioner based upon the average of percentages that represent the relationship of other program costs to direct services costs among the entities that provide similar services;

(iii) physical plant costs calculated based on the percentage of space within the program that is entirely devoted to treatment and programming. This does not include administrative or residential space; and

(iv) subject to federal approval, up to an additional five percent of the total rate may be added to the program rate as a quality incentive based upon the entity meeting performance criteria specified by the commissioner;

(2) actual costs are defined as costs which are allowable, allocable, and reasonable, and consistent with federal reimbursement requirements under Code of Federal Regulations, title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and Budget Uniform Guidance under Code of Federal Regulations, title 2, section 200, relating to nonprofit entities;

(3) the number of services units;

(4) the degree to which clients will receive services other than services under this section or section 256B.0622; and

(5) the costs of other services that will be separately reimbursed.

(e) The rate for intensive residential treatment services must exclude the medical assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services not covered under this section, such as partial hospitalization, home care, and inpatient services.

(f) Physician services that are not separately billed may be included in the rate to the extent that a psychiatrist, or other health care professional providing physician services within their scope of practice, is a member of the intensive residential treatment services treatment team. Physician services, whether billed separately or included in the rate, may be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth is used to provide intensive residential treatment services.

(g) The rate for a provider must not exceed the rate charged by that provider for the same service to other payors.

(h) The rates for existing programs must be established prospectively based upon the expenditures and utilization over a prior 12-month period using the criteria established in paragraph (d). The rates for new programs must be established based upon estimated expenditures and estimated utilization using the criteria established in paragraph (d).

(i) Effective upon the expiration of section 256B.0622, subdivision 8, paragraph (h), and effective for rate years beginning on and after January 1, 2024, rates for intensive residential treatment services and adult residential crisis stabilization services must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter of the calendar year before the rate year. The inflation adjustment must be based on the 12-month period from the midpoint of the previous rate year to the midpoint of the rate year for which the rate is being determined.

(j) Entities who discontinue providing services must be subject to a settle-up process whereby actual costs and reimbursement for the previous 12 months are compared. In the event that the entity was paid more than the entity's actual costs plus any applicable performance-related funding due the provider, the excess payment must be reimbursed to the department. If a provider's revenue is less than actual allowed costs due to lower utilization than projected, the commissioner may reimburse the provider to recover its actual allowable costs. The resulting adjustments by the commissioner must be proportional to the percent of total units of service reimbursed by the commissioner and must reflect a difference of greater than five percent.

(k) A provider may request of the commissioner a review of any rate-setting decision made under this subdivision.

Subd. 4. **Provider enrollment; rate setting for county-operated entities.** Counties that employ their own staff to provide services under this section shall apply directly to the commissioner for enrollment and rate setting. In this case, a county contract is not required.

Subd. 5. **Provider enrollment; rate setting for specialized program.** A county contract is not required for a provider proposing to serve a subpopulation of eligible clients under the following circumstances:

(1) the provider demonstrates that the subpopulation to be served requires a specialized program which is not available from county-approved entities; and

(2) the subpopulation to be served is of such a low incidence that it is not feasible to develop a program serving a single county or regional group of counties.

Subd. 6. **Sustainability grants.** The commissioner may disburse grant funds directly to intensive residential treatment services providers to maintain access to these services.

Subd. 7. **Start-up grants.** The commissioner may, within available appropriations, disburse grant funding to counties, Indian Tribes, or mental health service providers to establish additional intensive residential treatment services and residential crisis services.

Sec. 6. **REPEALER.**

Minnesota Statutes 2024, section 256B.0622, subdivision 4, is repealed.

ARTICLE 7

ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL TREATMENT SERVICES RECODIFICATION CONFORMING CHANGES

Section 1. Minnesota Statutes 2024, section 148F.11, subdivision 1, is amended to read:

Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of other professions or occupations from performing functions for which they are qualified or licensed. This exception includes, but is not limited to: licensed physicians; registered nurses; licensed practical nurses; licensed psychologists and licensed psychological practitioners; members of the clergy provided such services are provided within the scope of regular ministries; American Indian medicine men and women; licensed attorneys; probation officers; licensed marriage and family therapists; licensed social workers; social workers employed by city, county, or state agencies; licensed professional counselors; licensed professional clinical counselors; licensed school counselors; registered occupational therapists or occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders (UMICAD) certified counselors when providing services to Native American people; city, county, or state employees when providing assessments or case management under Minnesota Rules, chapter 9530; and staff persons providing co-occurring substance use disorder treatment in adult mental health rehabilitative programs certified or licensed by the Department of Human Services under section 245I.23, 256B.0622, ~~or~~ 256B.0623, or 256B.0632.

(b) Nothing in this chapter prohibits technicians and resident managers in programs licensed by the Department of Human Services from discharging their duties as provided in Minnesota Rules, chapter 9530.

(c) Any person who is exempt from licensure under this section must not use a title incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug counselor" or otherwise hold himself or herself out to the public by any title or description stating or implying that he or she is engaged in the practice of alcohol and drug counseling, or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the use of one of the titles in paragraph (a).

Sec. 2. Minnesota Statutes 2024, section 245.4662, subdivision 1, is amended to read:

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

(b) "Community partnership" means a project involving the collaboration of two or more eligible applicants.

(c) "Eligible applicant" means an eligible county, Indian tribe, mental health service provider, hospital, or community partnership. Eligible applicant does not include a state-operated direct care and treatment facility or program under chapters 246 and 246C.

(d) "Intensive residential treatment services" has the meaning given in section ~~256B.0622~~ 256B.0632.

(e) "Metropolitan area" means the seven-county metropolitan area, as defined in section 473.121, subdivision 2.

Sec. 3. Minnesota Statutes 2024, section 245.4906, subdivision 2, is amended to read:

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider that employs a mental health certified peer specialist qualified under section 245I.04, subdivision 10, and that provides services to individuals receiving assertive community treatment ~~or intensive residential treatment services~~ under section 256B.0622, intensive residential treatment services under section 256B.0632, adult rehabilitative mental health services under section 256B.0623, or crisis response services under section 256B.0624.

Sec. 4. Minnesota Statutes 2024, section 254B.04, subdivision 1a, is amended to read:

Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal Regulations, title 25, part 20, who meet the income standards of section 256B.056, subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health fund services. State money appropriated for this paragraph must be placed in a separate account established for this purpose.

(b) Persons with dependent children who are determined to be in need of substance use disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in need of chemical dependency treatment pursuant to a case plan under section 260C.201, subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment services. Treatment services must be appropriate for the individual or family, which may include long-term care treatment or treatment in a facility that allows the dependent children to stay in the treatment facility. The county shall pay for out-of-home placement costs, if applicable.

(c) Notwithstanding paragraph (a), any person enrolled in medical assistance or MinnesotaCare is eligible for room and board services under section 254B.05, subdivision 5, paragraph (b), clause (9).

(d) A client is eligible to have substance use disorder treatment paid for with funds from the behavioral health fund when the client:

(1) is eligible for MFIP as determined under chapter 142G;

(2) is eligible for medical assistance as determined under Minnesota Rules, parts 9505.0010 to 9505.0150;

(3) is eligible for general assistance, general assistance medical care, or work readiness as determined under Minnesota Rules, parts 9500.1200 to 9500.1318; or

(4) has income that is within current household size and income guidelines for entitled persons, as defined in this subdivision and subdivision 7.

(e) Clients who meet the financial eligibility requirement in paragraph (a) and who have a third-party payment source are eligible for the behavioral health fund if the third-party payment source pays less than 100 percent of the cost of treatment services for eligible clients.

(f) A client is ineligible to have substance use disorder treatment services paid for with behavioral health fund money if the client:

(1) has an income that exceeds current household size and income guidelines for entitled persons as defined in this subdivision and subdivision 7; or

(2) has an available third-party payment source that will pay the total cost of the client's treatment.

(g) A client who is disenrolled from a state prepaid health plan during a treatment episode is eligible for continued treatment service that is paid for by the behavioral health fund until the treatment episode is completed or the client is re-enrolled in a state prepaid health plan if the client:

(1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance medical care; or

(2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local agency under section 254B.04.

(h) When a county commits a client under chapter 253B to a regional treatment center for substance use disorder services and the client is ineligible for the behavioral health fund, the county is responsible for the payment to the regional treatment center according to section 254B.05, subdivision 4.

(i) Persons enrolled in MinnesotaCare are eligible for room and board services when provided through intensive residential treatment services and residential crisis services under section ~~256B.0622~~ 256B.0632.

Sec. 5. Minnesota Statutes 2024, section 254B.05, subdivision 1a, is amended to read:

Subd. 1a. **Room and board provider 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 licensed according to Minnesota Rules, chapter 2960, are exempt from paragraph (a), clauses (5) to (15).

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

(d) 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.

(e) Licensed programs providing intensive residential treatment services or residential crisis stabilization services pursuant to section ~~256B.0622 or~~ 256B.0624 or 256B.0632 are eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

(f) 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.

Sec. 6. Minnesota Statutes 2024, section 256.478, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative if the individual can demonstrate that current services are not capable of meeting individual treatment and service needs that can be met in the community with support, and the individual meets at least one of the following criteria:

(1) the person meets the criteria under section 256B.092, subdivision 13, or 256B.49, subdivision 24;

(2) the person has met treatment objectives and no longer requires a hospital-level care, residential-level care, or a secure treatment setting, but the person's discharge from the Anoka Metro Regional Treatment Center, the Minnesota Forensic Mental Health Program, the Child and Adolescent Behavioral Health Hospital program, a psychiatric residential treatment facility under section 256B.0941, intensive residential treatment services under section ~~256B.0622~~ 256B.0632, children's residential services under section 245.4882, juvenile detention facility, county supervised building, or a hospital would be substantially delayed without additional resources available through the transitions to community initiative;

(3) the person (i) is receiving customized living services reimbursed under section 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or community residential services reimbursed under section 256B.4914; (ii) expresses a desire to move; and (iii) has received approval from the commissioner; or

(4) the person can demonstrate that the person's needs are beyond the scope of current service designs and grant funding can support the inclusion of additional supports for the person to access appropriate treatment and services in the least restrictive environment.

Sec. 7. Minnesota Statutes 2024, section 256B.0615, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist services, as established in subdivision 2, if provided to recipients who are eligible for services under sections 256B.0622, 256B.0623, ~~and~~ 256B.0624, and 256B.0632 and are provided by a mental health certified peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 10.

Sec. 8. Minnesota Statutes 2024, section 256B.0615, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** Peer support services may be made available to consumers of (1) intensive residential treatment services under section ~~256B.0622~~ 256B.0632; (2) adult rehabilitative mental health services under section 256B.0623; and (3) crisis stabilization and mental health mobile crisis intervention services under section 256B.0624.

Sec. 9. Minnesota Statutes 2024, section 256B.82, is amended to read:

256B.82 PREPAID PLANS AND MENTAL HEALTH REHABILITATIVE SERVICES.

Medical assistance and MinnesotaCare prepaid health plans may include coverage for adult mental health rehabilitative services under section 256B.0623, intensive rehabilitative services under section ~~256B.0622~~ 256B.0632, and adult mental health crisis response services under section 256B.0624, beginning January 1, 2005.

By January 15, 2004, the commissioner shall report to the legislature how these services should be included in prepaid plans. The commissioner shall consult with mental health advocates, health plans, and counties in developing this report. The report recommendations must include a plan to ensure coordination of these services between health plans and counties, assure recipient access to essential community providers, and monitor the health plans' delivery of services through utilization review and quality standards.

Sec. 10. Minnesota Statutes 2024, section 256D.44, subdivision 5, is amended to read:

Subd. 5. **Special needs.** (a) In addition to the state standards of assistance established in subdivisions 1 to 4, payments are allowed for the following special needs of recipients of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment center, or a setting authorized to receive housing support payments under chapter 256I.

(b) The county agency shall pay a monthly allowance for medically prescribed diets if the cost of those additional dietary needs cannot be met through some other maintenance benefit. The need for special diets or dietary items must be prescribed by a licensed physician, advanced practice registered nurse, or physician assistant. Costs for special diets shall be determined as percentages of the allotment for a one-person household under the thrifty food plan as defined by the United States Department of Agriculture. The types of diets and the percentages of the thrifty food plan that are covered are as follows:

(1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

(2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of thrifty food plan;

(3) controlled protein diet, less than 40 grams and requires special products, 125 percent of thrifty food plan;

(4) low cholesterol diet, 25 percent of thrifty food plan;

(5) high residue diet, 20 percent of thrifty food plan;

(6) pregnancy and lactation diet, 35 percent of thrifty food plan;

(7) gluten-free diet, 25 percent of thrifty food plan;

(8) lactose-free diet, 25 percent of thrifty food plan;

(9) antidumping diet, 15 percent of thrifty food plan;

(10) hypoglycemic diet, 15 percent of thrifty food plan; or

(11) ketogenic diet, 25 percent of thrifty food plan.

(c) Payment for nonrecurring special needs must be allowed for necessary home repairs or necessary repairs or replacement of household furniture and appliances using the payment standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as other funding sources are not available.

(d) A fee for guardian or conservator service is allowed at a reasonable rate negotiated by the county or approved by the court. This rate shall not exceed five percent of the assistance unit's gross monthly income up to a maximum of $100 per month. If the guardian or conservator is a member of the county agency staff, no fee is allowed.

(e) The county agency shall continue to pay a monthly allowance of $68 for restaurant meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and who eats two or more meals in a restaurant daily. The allowance must continue until the person has not received Minnesota supplemental aid for one full calendar month or until the person's living arrangement changes and the person no longer meets the criteria for the restaurant meal allowance, whichever occurs first.

(f) A fee equal to the maximum monthly amount allowed by the Social Security Administration is allowed for representative payee services provided by an agency that meets the requirements under SSI regulations to charge a fee for representative payee services. This special need is available to all recipients of Minnesota supplemental aid regardless of their living arrangement.

(g)(1) Notwithstanding the language in this subdivision, an amount equal to one-half of the maximum federal Supplemental Security Income payment amount for a single individual which is in effect on the first day of July of each year will be added to the standards of assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as in need of housing assistance and are:

(i) relocating from an institution, a setting authorized to receive housing support under chapter 256I, or an adult mental health residential treatment program under section ~~256B.0622~~ 256B.0632;

(ii) eligible for personal care assistance under section 256B.0659; or

(iii) home and community-based waiver recipients living in their own home or rented or leased apartment.

(2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter needy benefit under this paragraph is considered a household of one. An eligible individual who receives this benefit prior to age 65 may continue to receive the benefit after the age of 65.

(3) "Housing assistance" means that the assistance unit incurs monthly shelter costs that exceed 40 percent of the assistance unit's gross income before the application of this special needs standard. "Gross

income" for the purposes of this section is the applicant's or recipient's income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy, that limits shelter costs to a percentage of gross income, shall not be considered in need of housing assistance for purposes of this paragraph.

ARTICLE 8

CHILDREN'S MENTAL HEALTH TERMINOLOGY

Section 1. Minnesota Statutes 2024, section 62Q.527, subdivision 1, is amended to read:

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

~~(b) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.~~

~~(c)~~ (b) "Mental illness" has the meaning given in ~~section~~ sections 245.462, subdivision 20, paragraph (a), and 245.4871, subdivision 15.

~~(d)~~ (c) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes the coverages described in section 62A.011, subdivision 3, clauses (7) and (10).

Sec. 2. Minnesota Statutes 2024, section 62Q.527, subdivision 2, is amended to read:

Subd. 2. **Required coverage for antipsychotic drugs.** (a) A health plan that provides prescription drug coverage must provide coverage for an antipsychotic drug prescribed to treat ~~emotional disturbance or~~ mental illness regardless of whether the drug is in the health plan's drug formulary, if the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the health care provider has considered all equivalent drugs in the health plan's drug formulary and has determined that the drug prescribed will best treat the patient's condition.

(b) The health plan is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

(c) For drugs covered under this section, no health plan company that has received a certification from the health care provider as described in paragraph (a) may:

(1) impose a special deductible, co-payment, coinsurance, or other special payment requirement that the health plan does not apply to drugs that are in the health plan's drug formulary; or

(2) require written certification from the prescribing provider each time a prescription is refilled or renewed that the drug prescribed will best treat the patient's condition.

Sec. 3. Minnesota Statutes 2024, section 62Q.527, subdivision 3, is amended to read:

Subd. 3. **Continuing care.** (a) Enrollees receiving a prescribed drug to treat a diagnosed mental illness ~~or emotional disturbance~~ may continue to receive the prescribed drug for up to one year without the imposition

of a special deductible, co-payment, coinsurance, or other special payment requirements, when a health plan's drug formulary changes or an enrollee changes health plans and the medication has been shown to effectively treat the patient's condition. In order to be eligible for this continuing care benefit:

(1) the patient must have been treated with the drug for 90 days prior to a change in a health plan's drug formulary or a change in the enrollee's health plan;

(2) the health care provider prescribing the drug indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(3) the health care provider prescribing the drug certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(b) The continuing care benefit shall be extended annually when the health care provider prescribing the drug:

(1) indicates to the dispensing pharmacist, orally or in writing according to section 151.21, that the prescription must be dispensed as communicated; and

(2) certifies in writing to the health plan company that the drug prescribed will best treat the patient's condition.

(c) The health plan company is not required to provide coverage for a drug if the drug was removed from the health plan's drug formulary for safety reasons.

Sec. 4. Minnesota Statutes 2024, section 121A.61, subdivision 3, is amended to read:

Subd. 3. **Policy components.** The policy must include at least the following components:

(a) rules governing student conduct and procedures for informing students of the rules;

(b) the grounds for removal of a student from a class;

(c) the authority of the classroom teacher to remove students from the classroom pursuant to procedures and rules established in the district's policy;

(d) the procedures for removal of a student from a class by a teacher, school administrator, or other school district employee;

(e) the period of time for which a student may be removed from a class, which may not exceed five class periods for a violation of a rule of conduct;

(f) provisions relating to the responsibility for and custody of a student removed from a class;

(g) the procedures for return of a student to the specified class from which the student has been removed;

(h) the procedures for notifying a student and the student's parents or guardian of violations of the rules of conduct and of resulting disciplinary actions;

(i) any procedures determined appropriate for encouraging early involvement of parents or guardians in attempts to improve a student's behavior;

(j) any procedures determined appropriate for encouraging early detection of behavioral problems;

(k) any procedures determined appropriate for referring a student in need of special education services to those services;

(l) any procedures determined appropriate for ensuring victims of bullying who respond with behavior not allowed under the school's behavior policies have access to a remedial response, consistent with section 121A.031;

(m) the procedures for consideration of whether there is a need for a further assessment or of whether there is a need for a review of the adequacy of a current individualized education program of a student with a disability who is removed from class;

(n) procedures for detecting and addressing chemical abuse problems of a student while on the school premises;

(o) the minimum consequences for violations of the code of conduct;

(p) procedures for immediate and appropriate interventions tied to violations of the code;

(q) a provision that states that a teacher, school employee, school bus driver, or other agent of a district may use reasonable force in compliance with section 121A.582 and other laws;

(r) an agreement regarding procedures to coordinate crisis services to the extent funds are available with the county board responsible for implementing sections 245.487 to 245.4889 for students with a serious ~~emotional disturbance~~ mental illness or other students who have an individualized education program whose behavior may be addressed by crisis intervention;

(s) a provision that states a student must be removed from class immediately if the student engages in assault or violent behavior. For purposes of this paragraph, "assault" has the meaning given it in section 609.02, subdivision 10. The removal shall be for a period of time deemed appropriate by the principal, in consultation with the teacher;

(t) a prohibition on the use of exclusionary practices for early learners as defined in section 121A.425; and

(u) a prohibition on the use of exclusionary practices to address attendance and truancy issues.

Sec. 5. Minnesota Statutes 2024, section 128C.02, subdivision 5, is amended to read:

Subd. 5. **Rules for open enrollees.** (a) The league shall adopt league rules and regulations governing the athletic participation of pupils attending school in a nonresident district under section 124D.03.

(b) Notwithstanding other law or league rule or regulation to the contrary, when a student enrolls in or is readmitted to a recovery-focused high school after successfully completing a licensed program for treatment of alcohol or substance abuse~~,~~ or mental illness, ~~or emotional disturbance,~~ the student is immediately eligible to participate on the same basis as other district students in the league-sponsored activities of the student's resident school district. Nothing in this paragraph prohibits the league or school district from enforcing a league or district penalty resulting from the student violating a league or district rule.

(c) The league shall adopt league rules making a student with an individualized education program who transfers from one public school to another public school as a reasonable accommodation to reduce barriers to educational access immediately eligible to participate in league-sponsored varsity competition on the same basis as other students in the school to which the student transfers. The league also must establish guidelines, consistent with this paragraph, for reviewing the 504 plan of a student who transfers between

public schools to determine whether the student is immediately eligible to participate in league-sponsored varsity competition on the same basis as other students in the school to which the student transfers.

Sec. 6. Minnesota Statutes 2024, section 142G.02, subdivision 56, is amended to read:

Subd. 56. **Learning disabled.** "Learning disabled," for purposes of an extension to the 60-month time limit under section 142G.42, subdivision 4, clause (3), means the person has a disorder in one or more of the psychological processes involved in perceiving, understanding, or using concepts through verbal language or nonverbal means. Learning disabled does not include learning problems that are primarily the result of visual, hearing, or motor disabilities; developmental disability; ~~emotional disturbance;~~ or mental illness or due to environmental, cultural, or economic disadvantage.

Sec. 7. Minnesota Statutes 2024, section 142G.27, subdivision 4, is amended to read:

Subd. 4. **Good cause exemptions for not attending orientation.** (a) The county agency shall not impose the sanction under section 142G.70 if it determines that the participant has good cause for failing to attend orientation. Good cause exists when:

(1) appropriate child care is not available;

(2) the participant is ill or injured;

(3) a family member is ill and needs care by the participant that prevents the participant from attending orientation. For a caregiver with a child or adult in the household who meets the disability or medical criteria for home care services under section 256B.0659, or a home and community-based waiver services program under chapter 256B, or meets the criteria for ~~severe emotional disturbance~~ serious mental illness under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c), good cause also exists when an interruption in the provision of those services occurs which prevents the participant from attending orientation;

(4) the caregiver is unable to secure necessary transportation;

(5) the caregiver is in an emergency situation that prevents orientation attendance;

(6) the orientation conflicts with the caregiver's work, training, or school schedule; or

(7) the caregiver documents other verifiable impediments to orientation attendance beyond the caregiver's control.

(b) Counties must work with clients to provide child care and transportation necessary to ensure a caregiver has every opportunity to attend orientation.

Sec. 8. Minnesota Statutes 2024, section 142G.42, subdivision 3, is amended to read:

Subd. 3. **Ill or incapacitated.** (a) An assistance unit subject to the time limit in section 142G.40, subdivision 1, is eligible to receive months of assistance under a hardship extension if the participant who reached the time limit belongs to any of the following groups:

(1) participants who are suffering from an illness, injury, or incapacity which has been certified by a qualified professional when the illness, injury, or incapacity is expected to continue for more than 30 days and severely limits the person's ability to obtain or maintain suitable employment. These participants must follow the treatment recommendations of the qualified professional certifying the illness, injury, or incapacity;

(2) participants whose presence in the home is required as a caregiver because of the illness, injury, or incapacity of another member in the assistance unit, a relative in the household, or a foster child in the household when the illness or incapacity and the need for a person to provide assistance in the home has been certified by a qualified professional and is expected to continue for more than 30 days; or

(3) caregivers with a child or an adult in the household who meets the disability or medical criteria for home care services under section 256B.0651, subdivision 1, paragraph (c), or a home and community-based waiver services program under chapter 256B, or meets the criteria for ~~severe emotional disturbance~~ serious mental illness under section 245.4871, subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision 20, paragraph (c). Caregivers in this category are presumed to be prevented from obtaining or maintaining suitable employment.

(b) An assistance unit receiving assistance under a hardship extension under this subdivision may continue to receive assistance as long as the participant meets the criteria in paragraph (a), clause (1), (2), or (3).

Sec. 9. Minnesota Statutes 2024, section 245.462, 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 section 245.4711.

(b) A case manager must:

(1) be skilled in the process of identifying and assessing a wide range of client needs;

(2) be knowledgeable about local community resources and how to use those resources for the benefit of the client;

(3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have a bachelor's degree in one of the behavioral sciences or related fields including, but not limited to, social work, psychology, or nursing from an accredited college or university. A case manager who is not a mental health practitioner and who does not have a bachelor's degree in one of the behavioral sciences or related fields must meet the requirements of paragraph (c); and

(4) meet the supervision and continuing education requirements described in paragraphs (d), (e), and (f), as applicable.

(c) Case managers without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(1) have three or four years of experience as a case manager associate as defined in this section;

(2) be a registered nurse without a bachelor's degree and have 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; or

(3) be a person who qualified as a case manager under the 1998 Department of Human Service waiver provision and meet the continuing education and mentoring requirements in this section.

(d) A case manager with at least 2,000 hours of supervised experience in the delivery of services to adults with mental illness 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 remaining 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. Clinical supervision must be documented in the client record.

(e) A case manager without 2,000 hours of supervised experience in the delivery of services to adults with mental illness must:

(1) receive clinical supervision regarding individual service delivery from a mental health professional at least one hour per week until the requirement of 2,000 hours of experience is met; and

(2) complete 40 hours of training approved by the commissioner in case management skills and the characteristics and needs of adults with serious and persistent mental illness.

(f) 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 mental illness and mental health services every two years.

(g) 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 certified peer specialist under section 256B.0615;

(iii) be a registered nurse without a bachelor's degree;

(iv) within the previous ten years, have three years of life experience with serious and persistent mental illness as defined in subdivision 20; ~~or~~ as a child had ~~severe emotional disturbance~~ a serious mental illness as defined in section 245.4871, subdivision 6; or have three years life experience as a primary caregiver to an adult with serious and persistent mental illness within the previous ten years;

(v) have 6,000 hours work experience as a nondegreed state hospital technician; or

(vi) have at least 6,000 hours of supervised experience in the delivery of services to persons with mental illness.

Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager after four years of supervised work experience as a case manager associate. Individuals meeting the criteria in item (vi) may qualify as a case manager after three years of supervised experience as a case manager associate.

(h) A case management associate must meet the following supervision, mentoring, and continuing education requirements:

(1) have 40 hours of preservice training described under paragraph (e), clause (2);

(2) receive at least 40 hours of continuing education in mental illness and mental health services 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.

(i) A case management supervisor must meet the criteria for mental health professionals, as specified in subdivision 18.

(j) An immigrant who does not have the qualifications specified in this subdivision may provide case management services to adult immigrants with serious and persistent mental illness who are members of the same ethnic group as the case manager 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 a related field including, but not limited to, social work, psychology, or nursing from 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 this subdivision are met.

Sec. 10. Minnesota Statutes 2024, section 245.4682, subdivision 3, is amended to read:

Subd. 3. **Projects for coordination of care.** (a) Consistent with section 256B.69 and chapter 256L, the commissioner is authorized to solicit, approve, and implement up to three projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner shall require that each project be based on locally defined partnerships that include at least one health maintenance organization, community integrated service network, or accountable provider network authorized and operating under chapter 62D, 62N, or 62T, or county-based purchasing entity under section 256B.692 that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the service area. Counties shall retain responsibility and authority for social services in these locally defined partnerships.

(b) The commissioner, in consultation with consumers, families, and their representatives, shall:

(1) determine criteria for approving the projects and use those criteria to solicit proposals for preferred integrated networks. The commissioner must develop criteria to evaluate the partnership proposed by the county and prepaid health plan to coordinate access and delivery of services. The proposal must at a minimum address how the partnership will coordinate the provision of:

(i) client outreach and identification of health and social service needs paired with expedited access to appropriate resources;

(ii) activities to maintain continuity of health care coverage;

(iii) children's residential mental health treatment and treatment foster care;

(iv) court-ordered assessments and treatments;

(v) prepetition screening and commitments under chapter 253B;

(vi) assessment and treatment of children identified through mental health screening of child welfare and juvenile corrections cases;

(vii) home and community-based waiver services;

(viii) assistance with finding and maintaining employment;

(ix) housing; and

(x) transportation;

(2) determine specifications for contracts with prepaid health plans to improve the plan's ability to serve persons with mental health conditions, including specifications addressing:

(i) early identification and intervention of physical and behavioral health problems;

(ii) communication between the enrollee and the health plan;

(iii) facilitation of enrollment for persons who are also eligible for a Medicare special needs plan offered by the health plan;

(iv) risk screening procedures;

(v) health care coordination;

(vi) member services and access to applicable protections and appeal processes;

(vii) specialty provider networks;

(viii) transportation services;

(ix) treatment planning; and

(x) administrative simplification for providers;

(3) begin implementation of the projects no earlier than January 1, 2009, with not more than 40 percent of the statewide population included during calendar year 2009 and additional counties included in subsequent years;

(4) waive any administrative rule not consistent with the implementation of the projects;

(5) allow potential bidders at least 90 days to respond to the request for proposals; and

(6) conduct an independent evaluation to determine if mental health outcomes have improved in that county or counties according to measurable standards designed in consultation with the advisory body established under this subdivision and reviewed by the State Advisory Council on Mental Health.

(c) Notwithstanding any statute or administrative rule to the contrary, the commissioner may enroll all persons eligible for medical assistance with serious mental illness ~~or emotional disturbance~~ in the prepaid plan of their choice within the project service area unless:

(1) the individual is eligible for home and community-based services for persons with developmental disabilities and related conditions under section 256B.092; or

(2) the individual has a basis for exclusion from the prepaid plan under section 256B.69, subdivision 4, other than disability, or mental illness~~, or emotional disturbance~~.

(d) The commissioner shall involve organizations representing persons with mental illness and their families in the development and distribution of information used to educate potential enrollees regarding their options for health care and mental health service delivery under this subdivision.

(e) If the person described in paragraph (c) does not elect to remain in fee-for-service medical assistance, or declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the preferred integrated network. The commissioner shall implement the enrollment changes within a project's service area on the timeline specified in that project's approved application.

(f) A person enrolled in a prepaid health plan under paragraphs (c) and (d) may disenroll from the plan at any time.

(g) The commissioner, in consultation with consumers, families, and their representatives, shall evaluate the projects begun in 2009, and shall refine the design of the service integration projects before expanding the projects. The commissioner shall report to the chairs of the legislative committees with jurisdiction over mental health services by March 1, 2008, on plans for evaluation of preferred integrated networks established under this subdivision.

(h) The commissioner shall apply for any federal waivers necessary to implement these changes.

(i) Payment for Medicaid service providers under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

Sec. 11. Minnesota Statutes 2024, 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 ~~with emotional disturbance~~ 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, and 256B.0623, 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. 12. Minnesota Statutes 2024, section 245.4863, is amended to read:

245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.

(a) The commissioner shall require individuals who perform substance use disorder assessments to screen clients for co-occurring mental health disorders, and staff who perform mental health diagnostic assessments to screen for co-occurring substance use disorders. Screening tools must be approved by the commissioner. If a client screens positive for a co-occurring mental health or substance use disorder, the individual performing the screening must document what actions will be taken in response to the results and whether further assessments must be performed.

(b) Notwithstanding paragraph (a), screening is not required when:

(1) the presence of co-occurring disorders was documented for the client in the past 12 months;

(2) the client is currently receiving co-occurring disorders treatment;

(3) the client is being referred for co-occurring disorders treatment; or

(4) a mental health professional who is competent to perform diagnostic assessments of co-occurring disorders is performing a diagnostic assessment to identify whether the client may have co-occurring mental health and substance use disorders. If an individual is identified to have co-occurring mental health and substance use disorders, the assessing mental health professional must document what actions will be taken to address the client's co-occurring disorders.

(c) The commissioner shall adopt rules as necessary to implement this section. The commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing a certification process for integrated dual disorder treatment providers and a system through which individuals receive integrated dual diagnosis treatment if assessed as having both a substance use disorder and ~~either~~ a serious mental illness ~~or emotional disturbance~~.

(d) The commissioner shall apply for any federal waivers necessary to secure, to the extent allowed by law, federal financial participation for the provision of integrated dual diagnosis treatment to persons with co-occurring disorders.

Sec. 13. Minnesota Statutes 2024, section 245.487, subdivision 2, is amended to read:

Subd. 2. **Findings.** The legislature finds there is a need for further development of existing clinical services for ~~emotionally disturbed~~ children with mental illness and their families and the creation of new services for this population. Although the services specified in sections 245.487 to 245.4889 are mental health services, sections 245.487 to 245.4889 emphasize the need for a child-oriented and family-oriented approach of therapeutic programming and the need for continuity of care with other community agencies. At the same time, sections 245.487 to 245.4889 emphasize the importance of developing special mental health expertise in children's mental health services because of the unique needs of this population.

Nothing in sections 245.487 to 245.4889 shall be construed to abridge the authority of the court to make dispositions under chapter 260, but the mental health services due any child with serious and persistent mental illness, as defined in section 245.462, subdivision 20, or with ~~severe emotional disturbance~~ a serious mental illness, as defined in section 245.4871, subdivision 6, shall be made a part of any disposition affecting that child.

Sec. 14. Minnesota Statutes 2024, section 245.4871, subdivision 3, is amended to read:

Subd. 3. **Case management services.** "Case management services" means activities that are coordinated with the family community support services and are designed to help the child with ~~severe emotional disturbance~~ serious mental illness and the child's family obtain needed mental health services, social services, educational services, health services, vocational services, recreational services, and related services in the areas of volunteer services, advocacy, transportation, and legal services. Case management services include assisting in obtaining a comprehensive diagnostic assessment, developing an individual family community support plan, and assisting the child and the child's family in obtaining needed services by coordination with other agencies and assuring continuity of care. Case managers must assess and reassess the delivery, appropriateness, and effectiveness of services over time.

Sec. 15. Minnesota Statutes 2024, 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 ~~severe emotional disturbance~~ serious mental illness and the child's family.

(b) A case manager must:

(1) have experience and training in working with children;

(2) 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 without a bachelor's degree must meet one of the requirements in clauses (1) to (3):

(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; or

(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.

(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 ~~emotional disturbance~~ 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 ~~severe emotional disturbance~~ 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 ~~severe emotional disturbance~~ 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 ~~emotional disturbance~~ 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 ~~emotional disturbances~~ mental illness; hours worked as a mental health behavioral aide I or II under section 256B.0943, subdivision 7, 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 ~~severe emotional disturbance~~ 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 ~~severe emotional disturbance~~ 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. 16. Minnesota Statutes 2024, section 245.4871, subdivision 6, is amended to read:

Subd. 6. **Child with ~~severe emotional disturbance~~ serious mental illness.** For purposes of eligibility for case management and family community support services, "child with ~~severe emotional disturbance~~ serious mental illness" means a child who has ~~an emotional disturbance~~ a mental illness and who meets one of the following criteria:

(1) the child has been admitted within the last three years or is at risk of being admitted to inpatient treatment or residential treatment for ~~an emotional disturbance~~ a mental illness; or

(2) the child is a Minnesota resident and is receiving inpatient treatment or residential treatment for ~~an emotional disturbance~~ a mental illness through the interstate compact; or

(3) the child has one of the following as determined by a mental health professional:

(i) psychosis or a clinical depression; or

(ii) risk of harming self or others as a result of ~~an emotional disturbance~~ a mental illness; or

(iii) psychopathological symptoms as a result of being a victim of physical or sexual abuse or of psychic trauma within the past year; or

(4) the child, as a result of ~~an emotional disturbance~~ a mental illness, has significantly impaired home, school, or community functioning that has lasted at least one year or that, in the written opinion of a mental health professional, presents substantial risk of lasting at least one year.

Sec. 17. Minnesota Statutes 2024, section 245.4871, subdivision 13, is amended to read:

Subd. 13. **Education and prevention services.** (a) "Education and prevention services" means services designed to:

(1) educate the general public;

(2) increase the understanding and acceptance of problems associated with ~~emotional disturbances~~ children's mental illnesses;

(3) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning; and

(4) refer specific children or their families with mental health needs to mental health services.

(b) The services include distribution to individuals and agencies identified by the county board and the local children's mental health advisory council of information on predictors and symptoms of ~~emotional disturbances~~ mental illnesses, where mental health services are available in the county, and how to access the services.

Sec. 18. Minnesota Statutes 2024, section 245.4871, subdivision 15, is amended to read:

Subd. 15. **~~Emotional disturbance~~ Mental illness.** ~~"Emotional disturbance"~~ "Mental illness" means an organic disorder of the brain or a clinically significant disorder of thought, mood, perception, orientation, memory, or behavior that:

(1) is detailed in a diagnostic codes list published by the commissioner; and

(2) seriously limits a child's capacity to function in primary aspects of daily living such as personal relations, living arrangements, work, school, and recreation.

~~"Emotional disturbance"~~ Mental illness is a generic term and is intended to reflect all categories of disorder described in the clinical code list published by the commissioner as "usually first evident in childhood or adolescence."

Sec. 19. Minnesota Statutes 2024, section 245.4871, subdivision 17, is amended to read:

Subd. 17. **Family community support services.** "Family community support services" means services provided under the treatment supervision of a mental health professional and designed to help each child with ~~severe emotional disturbance~~ serious mental illness to function and remain with the child's family in the community. Family community support services do not include acute care hospital inpatient treatment, residential treatment services, or regional treatment center services. Family community support services include:

(1) client outreach to each child with ~~severe emotional disturbance~~ serious mental illness and the child's family;

(2) medication monitoring where necessary;

(3) assistance in developing independent living skills;

(4) assistance in developing parenting skills necessary to address the needs of the child with ~~severe emotional disturbance~~ serious mental illness;

(5) assistance with leisure and recreational activities;

(6) crisis planning, including crisis placement and respite care;

(7) professional home-based family treatment;

(8) foster care with therapeutic supports;

(9) day treatment;

(10) assistance in locating respite care and special needs day care; and

(11) assistance in obtaining potential financial resources, including those benefits listed in section 245.4884, subdivision 5.

Sec. 20. Minnesota Statutes 2024, section 245.4871, subdivision 19, is amended to read:

Subd. 19. **Individual family community support plan.** "Individual family community support plan" means a written plan developed by a case manager in conjunction with the family and the child with ~~severe emotional disturbance~~ serious mental illness on the basis of a diagnostic assessment and a functional assessment. The plan identifies specific services needed by a child and the child's family to:

(1) treat the symptoms and dysfunctions determined in the diagnostic assessment;

(2) relieve conditions leading to ~~emotional disturbance~~ mental illness and improve the personal well-being of the child;

(3) improve family functioning;

(4) enhance daily living skills;

(5) improve functioning in education and recreation settings;

(6) improve interpersonal and family relationships;

(7) enhance vocational development; and

(8) assist in obtaining transportation, housing, health services, and employment.

Sec. 21. Minnesota Statutes 2024, section 245.4871, subdivision 21, is amended to read:

Subd. 21. **Individual treatment plan.** (a) "Individual treatment plan" means the formulation of planned services that are responsive to the needs and goals of a client. An individual treatment plan must be completed according to section 245I.10, subdivisions 7 and 8.

(b) A children's residential facility licensed under Minnesota Rules, chapter 2960, is exempt from the requirements of section 245I.10, subdivisions 7 and 8. Instead, the individual treatment plan must:

(1) include a written plan of intervention, treatment, and services for a child with ~~an emotional disturbance~~ a mental illness that the service provider develops under the clinical supervision of a mental health professional on the basis of a diagnostic assessment;

(2) be developed in conjunction with the family unless clinically inappropriate; and

(3) identify goals and objectives of treatment, treatment strategy, a schedule for accomplishing treatment goals and objectives, and the individuals responsible for providing treatment to the child with ~~an emotional disturbance~~ a mental illness.

Sec. 22. Minnesota Statutes 2024, section 245.4871, subdivision 22, is amended to read:

Subd. 22. **Legal representative.** "Legal representative" means a guardian, conservator, or guardian ad litem of a child with ~~an emotional disturbance~~ a mental illness authorized by the court to make decisions about mental health services for the child.

Sec. 23. Minnesota Statutes 2024, section 245.4871, subdivision 28, is amended to read:

Subd. 28. **Mental health services.** "Mental health services" means at least all of the treatment services and case management activities that are provided to children with ~~emotional disturbances~~ mental illnesses and are described in sections 245.487 to 245.4889.

Sec. 24. Minnesota Statutes 2024, section 245.4871, subdivision 29, is amended to read:

Subd. 29. **Outpatient services.** "Outpatient services" means mental health services, excluding day treatment and community support services programs, provided by or under the treatment supervision of a mental health professional to children with ~~emotional disturbances~~ mental illnesses who live outside a hospital. Outpatient services include clinical activities such as individual, group, and family therapy; individual treatment planning; diagnostic assessments; medication management; and psychological testing.

Sec. 25. Minnesota Statutes 2024, section 245.4871, subdivision 32, is amended to read:

Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program under the treatment supervision of a mental health professional, in a community residential setting other than an acute care hospital or regional treatment center inpatient unit, that must be licensed as a residential treatment program for children with ~~emotional disturbances~~ mental illnesses under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted by the commissioner.

Sec. 26. Minnesota Statutes 2024, section 245.4871, subdivision 34, is amended to read:

Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care" means the mental health training and mental health support services and treatment supervision provided by a mental health professional to foster families caring for children with ~~severe emotional disturbance~~ serious mental illnesses to provide a therapeutic family environment and support for the child's improved functioning. Therapeutic support of foster care includes services provided under section 256B.0946.

Sec. 27. Minnesota Statutes 2024, section 245.4873, subdivision 2, is amended to read:

Subd. 2. **State level; coordination.** The Children's Cabinet, under section 4.045, in consultation with a representative of the Minnesota District Judges Association Juvenile Committee, shall:

(1) educate each agency about the policies, procedures, funding, and services for children with ~~emotional disturbances~~ mental illnesses of all agencies represented;

(2) develop mechanisms for interagency coordination on behalf of children with ~~emotional disturbances~~ mental illnesses;

(3) identify barriers including policies and procedures within all agencies represented that interfere with delivery of mental health services for children;

(4) recommend policy and procedural changes needed to improve development and delivery of mental health services for children in the agency or agencies they represent; and

(5) identify mechanisms for better use of federal and state funding in the delivery of mental health services for children.

Sec. 28. Minnesota Statutes 2024, section 245.4875, subdivision 5, is amended to read:

Subd. 5. **Local children's advisory council.** (a) By October 1, 1989, the county board, individually or in conjunction with other county boards, shall establish a local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council or shall include persons on its existing mental health advisory council who are representatives of children's mental health interests. The following individuals must serve on the local children's mental health advisory council, the children's mental health subcommittee of an existing local mental health advisory council, or be included on an existing mental health advisory council: (1) at least one person who was in a mental health program as a child or adolescent; (2) at least one parent of a child or adolescent with ~~severe emotional disturbance~~ serious mental illness; (3) one children's mental health professional; (4) representatives of minority populations of significant size residing in the county; (5) a representative of the children's mental health local coordinating council; and (6) one family community support services program representative.

(b) The local children's mental health advisory council or children's mental health subcommittee of an existing advisory council shall seek input from parents, former consumers, providers, and others about the needs of children with ~~emotional disturbance~~ mental illness in the local area and services needed by families of these children, and shall meet monthly, unless otherwise determined by the council or subcommittee, but not less than quarterly, to review, evaluate, and make recommendations regarding the local children's mental health system. Annually, the local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council shall:

(1) arrange for input from the local system of care providers regarding coordination of care between the services;

(2) identify for the county board the individuals, providers, agencies, and associations as specified in section 245.4877, clause (2); and

(3) provide to the county board a report of unmet mental health needs of children residing in the county.

(c) The county board shall consider the advice of its local children's mental health advisory council or children's mental health subcommittee of the existing local mental health advisory council in carrying out its authorities and responsibilities.

Sec. 29. Minnesota Statutes 2024, section 245.4876, subdivision 4, is amended to read:

Subd. 4. **Referral for case management.** Each provider of emergency services, outpatient treatment, community support services, family community support services, day treatment services, screening under section 245.4885, professional home-based family treatment services, residential treatment facilities, acute care hospital inpatient treatment facilities, or regional treatment center services must inform each child with ~~severe emotional disturbance~~ serious mental illness, and the child's parent or legal representative, of the availability and potential benefits to the child of case management. The information shall be provided as

specified in subdivision 5. If consent is obtained according to subdivision 5, the provider must refer the child by notifying the county employee designated by the county board to coordinate case management activities of the child's name and address and by informing the child's family of whom to contact to request case management. The provider must document compliance with this subdivision in the child's record. The parent or child may directly request case management even if there has been no referral.

Sec. 30. Minnesota Statutes 2024, section 245.4876, subdivision 5, is amended to read:

Subd. 5. **Consent for services or for release of information.** (a) Although sections 245.487 to 245.4889 require each county board, within the limits of available resources, to make the mental health services listed in those sections available to each child residing in the county who needs them, the county board shall not provide any services, either directly or by contract, unless consent to the services is obtained under this subdivision. The case manager assigned to a child with a ~~severe emotional disturbance~~ serious mental illness shall not disclose to any person other than the case manager's immediate supervisor and the mental health professional providing clinical supervision of the case manager information on the child, the child's family, or services provided to the child or the child's family without informed written consent unless required to do so by statute or under the Minnesota Government Data Practices Act. Informed written consent must comply with section 13.05, subdivision 4, paragraph (d), and specify the purpose and use for which the case manager may disclose the information.

(b) The consent or authorization must be obtained from the child's parent unless: (1) the parental rights are terminated; or (2) consent is otherwise provided under sections 144.341 to 144.347; 253B.04, subdivision 1; 260C.148; 260C.151; and 260C.201, subdivision 1, the terms of appointment of a court-appointed guardian or conservator, or federal regulations governing substance use disorder services.

Sec. 31. Minnesota Statutes 2024, section 245.4877, is amended to read:

245.4877 EDUCATION AND PREVENTION SERVICES.

Education and prevention services must be available to all children residing in the county. Education and prevention services must be designed to:

(1) convey information regarding ~~emotional disturbances~~ mental illnesses, mental health needs, and treatment resources to the general public;

(2) at least annually, distribute to individuals and agencies identified by the county board and the local children's mental health advisory council information on predictors and symptoms of ~~emotional disturbances~~ mental illnesses, where mental health services are available in the county, and how to access the services;

(3) increase understanding and acceptance of problems associated with ~~emotional disturbances~~ mental illnesses;

(4) improve people's skills in dealing with high-risk situations known to affect children's mental health and functioning;

(5) prevent development or deepening of ~~emotional disturbances~~ mental illnesses; and

(6) refer each child with ~~emotional disturbance~~ mental illness or the child's family with additional mental health needs to appropriate mental health services.

Sec. 32. Minnesota Statutes 2024, section 245.488, subdivision 1, is amended to read:

Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or contract for enough outpatient services within the county to meet the needs of each child with ~~emotional disturbance~~ mental illness residing in the county and the child's family. Services may be provided directly by the county through county-operated mental health clinics meeting the standards of chapter 245I; by contract with privately operated mental health clinics meeting the standards of chapter 245I; by contract with hospital mental health outpatient programs certified by the Joint Commission on Accreditation of Hospital Organizations; or by contract with a mental health professional. A child or a child's parent may be required to pay a fee based in accordance with section 245.481. Outpatient services include:

(1) conducting diagnostic assessments;

(2) conducting psychological testing;

(3) developing or modifying individual treatment plans;

(4) making referrals and recommending placements as appropriate;

(5) treating the child's mental health needs through therapy; and

(6) prescribing and managing medication and evaluating the effectiveness of prescribed medication.

(b) County boards may request a waiver allowing outpatient services to be provided in a nearby trade area if it is determined that the child requires necessary and appropriate services that are only available outside the county.

(c) Outpatient services offered by the county board to prevent placement must be at the level of treatment appropriate to the child's diagnostic assessment.

Sec. 33. Minnesota Statutes 2024, section 245.488, subdivision 3, is amended to read:

Subd. 3. **Mental health crisis services.** County boards must provide or contract for mental health crisis services within the county to meet the needs of children with ~~emotional disturbance~~ mental illness residing in the county who are determined, through an assessment by a mental health professional, to be experiencing a mental health crisis or mental health emergency. The mental health crisis services provided must be medically necessary, as defined in section 62Q.53, subdivision 2, and necessary for the safety of the child or others regardless of the setting.

Sec. 34. Minnesota Statutes 2024, section 245.4881, subdivision 1, is amended to read:

Subdivision 1. **Availability of case management services.** (a) The county board shall provide case management services for each child with ~~severe emotional disturbance~~ serious mental illness who is a resident of the county and the child's family who request or consent to the services. Case management services must be offered to a child with a serious ~~emotional disturbance~~ mental illness who is over the age of 18 consistent with section 245.4875, subdivision 8, or the child's legal representative, provided the child's service needs can be met within the children's service system. Before discontinuing case management services under this subdivision for children between the ages of 17 and 21, a transition plan must be developed. The transition plan must be developed with the child and, with the consent of a child age 18 or over, the child's parent, guardian, or legal representative. The transition plan should include plans for health insurance, housing, education, employment, and treatment. Staffing ratios must be sufficient to serve the needs of the clients. The case manager must meet the requirements in section 245.4871, subdivision 4.

(b) Except as permitted by law and the commissioner under demonstration projects, case management services provided to children with ~~severe emotional disturbance~~ serious mental illness eligible for medical assistance must be billed to the medical assistance program under sections 256B.02, subdivision 8, and 256B.0625.

(c) Case management services are eligible for reimbursement under the medical assistance program. Costs of mentoring, supervision, and continuing education may be included in the reimbursement rate methodology used for case management services under the medical assistance program.

Sec. 35. Minnesota Statutes 2024, section 245.4881, subdivision 4, is amended to read:

Subd. 4. **Individual family community support plan.** (a) For each child, the case manager must develop an individual family community support plan that incorporates the child's individual treatment plan. The individual treatment plan may not be a substitute for the development of an individual family community support plan. The case manager is responsible for developing the individual family community support plan within 30 days of intake based on a diagnostic assessment and for implementing and monitoring the delivery of services according to the individual family community support plan. The case manager must review the plan at least every 180 calendar days after it is developed, unless the case manager has received a written request from the child's family or an advocate for the child for a review of the plan every 90 days after it is developed. To the extent appropriate, the child with ~~severe emotional disturbance~~ serious mental illness, the child's family, advocates, service providers, and significant others must be involved in all phases of development and implementation of the individual family community support plan. Notwithstanding the lack of an individual family community support plan, the case manager shall assist the child and child's family in accessing the needed services listed in section 245.4884, subdivision 1.

(b) The child's individual family community support plan must state:

(1) the goals and expected outcomes of each service and criteria for evaluating the effectiveness and appropriateness of the service;

(2) the activities for accomplishing each goal;

(3) a schedule for each activity; and

(4) the frequency of face-to-face contacts by the case manager, as appropriate to client need and the implementation of the individual family community support plan.

Sec. 36. Minnesota Statutes 2024, section 245.4882, subdivision 1, is amended to read:

Subdivision 1. **Availability of residential treatment services.** County boards must provide or contract for enough residential treatment services to meet the needs of each child with ~~severe emotional disturbance~~ serious mental illness residing in the county and needing this level of care. Length of stay is based on the child's residential treatment need and shall be reviewed every 90 days. Services must be appropriate to the child's age and treatment needs and must be made available as close to the county as possible. Residential treatment must be designed to:

(1) help the child improve family living and social interaction skills;

(2) help the child gain the necessary skills to return to the community;

(3) stabilize crisis admissions; and

(4) work with families throughout the placement to improve the ability of the families to care for children with ~~severe emotional disturbance~~ serious mental illness in the home.

Sec. 37. Minnesota Statutes 2024, section 245.4882, subdivision 5, is amended to read:

Subd. 5. **Specialized residential treatment services.** The commissioner of human services shall continue efforts to further interagency collaboration to develop a comprehensive system of services, including family community support and specialized residential treatment services for children. The services shall be designed for children with ~~emotional disturbance~~ mental illness who exhibit violent or destructive behavior and for whom local treatment services are not feasible due to the small number of children statewide who need the services and the specialized nature of the services required. The services shall be located in community settings.

Sec. 38. Minnesota Statutes 2024, section 245.4884, is amended to read:

245.4884 FAMILY COMMUNITY SUPPORT SERVICES.

Subdivision 1. **Availability of family community support services.** By July 1, 1991, county boards must provide or contract for sufficient family community support services within the county to meet the needs of each child with ~~severe emotional disturbance~~ serious mental illness who resides in the county and the child's family. Children or their parents may be required to pay a fee in accordance with section 245.481.

Family community support services must be designed to improve the ability of children with ~~severe emotional disturbance~~ serious mental illness to:

(1) manage basic activities of daily living;

(2) function appropriately in home, school, and community settings;

(3) participate in leisure time or community youth activities;

(4) set goals and plans;

(5) reside with the family in the community;

(6) participate in after-school and summer activities;

(7) make a smooth transition among mental health and education services provided to children; and

(8) make a smooth transition into the adult mental health system as appropriate.

In addition, family community support services must be designed to improve overall family functioning if clinically appropriate to the child's needs, and to reduce the need for and use of placements more intensive, costly, or restrictive both in the number of admissions and lengths of stay than indicated by the child's diagnostic assessment.

The commissioner of human services shall work with mental health professionals to develop standards for clinical supervision of family community support services. These standards shall be incorporated in rule and in guidelines for grants for family community support services.

Subd. 2. **Day treatment services provided.** (a) Day treatment services must be part of the family community support services available to each child with ~~severe emotional disturbance~~ serious mental illness

residing in the county. A child or the child's parent may be required to pay a fee according to section 245.481. Day treatment services must be designed to:

(1) provide a structured environment for treatment;

(2) provide support for residing in the community;

(3) prevent placements that are more intensive, costly, or restrictive than necessary to meet the child's need;

(4) coordinate with or be offered in conjunction with the child's education program;

(5) provide therapy and family intervention for children that are coordinated with education services provided and funded by schools; and

(6) operate during all 12 months of the year.

(b) County boards may request a waiver from including day treatment services if they can document that:

(1) alternative services exist through the county's family community support services for each child who would otherwise need day treatment services; and

(2) county demographics and geography make the provision of day treatment services cost ineffective and unfeasible.

Subd. 3. **Professional home-based family treatment provided.** (a) By January 1, 1991, county boards must provide or contract for sufficient professional home-based family treatment within the county to meet the needs of each child with ~~severe emotional disturbance~~ serious mental illness who is at risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care due to the child's ~~emotional disturbance~~ mental illness or who is returning to the home from ~~out-of-home placement~~ residential treatment or therapeutic foster care. The child or the child's parent may be required to pay a fee according to section 245.481. The county board shall require that all service providers of professional home-based family treatment set fee schedules approved by the county board that are based on the child's or family's ability to pay. The professional home-based family treatment must be designed to assist each child with ~~severe emotional disturbance~~ serious mental illness who is at risk of or who is returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care and the child's family to:

(1) improve overall family functioning in all areas of life;

(2) treat the child's symptoms of ~~emotional disturbance~~ mental illness that contribute to a risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care;

(3) provide a positive change in the emotional, behavioral, and mental well-being of children and their families; and

(4) reduce risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care for the identified child with ~~severe emotional disturbance~~ serious mental illness and other siblings or successfully reunify and reintegrate into the family a child returning from ~~out-of-home placement~~ residential treatment or therapeutic foster care due to ~~emotional disturbance~~ mental illness.

(b) Professional home-based family treatment must be provided by a team consisting of a mental health professional and others who are skilled in the delivery of mental health services to children and families in

conjunction with other human service providers. The professional home-based family treatment team must maintain flexible hours of service availability and must provide or arrange for crisis services for each family, 24 hours a day, seven days a week. Case loads for each professional home-based family treatment team must be small enough to permit the delivery of intensive services and to meet the needs of the family. Professional home-based family treatment providers shall coordinate services and service needs with case managers assigned to children and their families. The treatment team must develop an individual treatment plan that identifies the specific treatment objectives for both the child and the family.

Subd. 4. **Therapeutic support of foster care.** By January 1, 1992, county boards must provide or contract for foster care with therapeutic support as defined in section 245.4871, subdivision 34. Foster families caring for children with ~~severe emotional disturbance~~ serious mental illness must receive training and supportive services, as necessary, at no cost to the foster families within the limits of available resources.

Subd. 5. **Benefits assistance.** The county board must offer help to a child with ~~severe emotional disturbance~~ serious mental illness and the child's family in applying for federal benefits, including Supplemental Security Income, medical assistance, and Medicare.

Sec. 39. Minnesota Statutes 2024, section 245.4885, subdivision 1, is amended to read:

Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the case of an emergency, all children referred for treatment of ~~severe emotional disturbance~~ serious mental illness in a treatment foster care setting, residential treatment facility, or informally admitted to a regional treatment center shall undergo an assessment to determine the appropriate level of care if county funds are used to pay for the child's services. An emergency includes when a child is in need of and has been referred for crisis stabilization services under section 245.4882, subdivision 6. A child who has been referred to residential treatment for crisis stabilization services in a residential treatment center is not required to undergo an assessment under this section.

(b) The county board shall determine the appropriate level of care for a child when county-controlled funds are used to pay for the child's residential treatment under this chapter, including residential treatment provided in a qualified residential treatment program as defined in section 260C.007, subdivision 26d. When a county board does not have responsibility for a child's placement and the child is enrolled in a prepaid health program under section 256B.69, the enrolled child's contracted health plan must determine the appropriate level of care for the child. When Indian Health Services funds or funds of a tribally owned facility funded under the Indian Self-Determination and Education Assistance Act, Public Law 93-638, are used for the child, the Indian Health Services or 638 tribal health facility must determine the appropriate level of care for the child. When more than one entity bears responsibility for a child's coverage, the entities shall coordinate level of care determination activities for the child to the extent possible.

(c) The child's level of care determination shall determine whether the proposed treatment:

(1) is necessary;

(2) is appropriate to the child's individual treatment needs;

(3) cannot be effectively provided in the child's home; and

(4) provides a length of stay as short as possible consistent with the individual child's needs.

(d) When a level of care determination is conducted, the county board or other entity may not determine that a screening of a child, referral, or admission to a residential treatment facility is not appropriate solely

because services were not first provided to the child in a less restrictive setting and the child failed to make progress toward or meet treatment goals in the less restrictive setting. The level of care determination must be based on a diagnostic assessment of a child that evaluates the child's family, school, and community living situations; and an assessment of the child's need for care out of the home using a validated tool which assesses a child's functional status and assigns an appropriate level of care to the child. The validated tool must be approved by the commissioner of human services and may be the validated tool approved for the child's assessment under section 260C.704 if the juvenile treatment screening team recommended placement of the child in a qualified residential treatment program. If a diagnostic assessment has been completed by a mental health professional within the past 180 days, a new diagnostic assessment need not be completed unless in the opinion of the current treating mental health professional the child's mental health status has changed markedly since the assessment was completed. The child's parent shall be notified if an assessment will not be completed and of the reasons. A copy of the notice shall be placed in the child's file. Recommendations developed as part of the level of care determination process shall include specific community services needed by the child and, if appropriate, the child's family, and shall indicate whether these services are available and accessible to the child and the child's family. The child and the child's family must be invited to any meeting where the level of care determination is discussed and decisions regarding residential treatment are made. The child and the child's family may invite other relatives, friends, or advocates to attend these meetings.

(e) During the level of care determination process, the child, child's family, or child's legal representative, as appropriate, must be informed of the child's eligibility for case management services and family community support services and that an individual family community support plan is being developed by the case manager, if assigned.

(f) The level of care determination, placement decision, and recommendations for mental health services must be documented in the child's record and made available to the child's family, as appropriate.

Sec. 40. Minnesota Statutes 2024, section 245.4889, subdivision 1, is amended to read:

Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to make grants from available appropriations to assist:

(1) counties;

(2) Indian tribes;

(3) children's collaboratives under section 142D.15 or 245.493; or

(4) mental health service providers.

(b) The following services are eligible for grants under this section:

(1) services to children with ~~emotional disturbances~~ mental illness as defined in section 245.4871, subdivision 15, and their families;

(2) transition services under section 245.4875, subdivision 8, for young adults under age 21 and their families;

(3) respite care services for children with ~~emotional disturbances~~ mental illness or ~~severe emotional disturbances~~ serious mental illness who are at risk of residential treatment or hospitalization~~,~~; who are already in ~~out-of-home placement~~ residential treatment, therapeutic foster care, or in family foster settings as defined in chapter 142B and at risk of change in ~~out-of-home placement~~ foster care or placement in a residential

facility or other higher level of care~~,~~; who have utilized crisis services or emergency room services~~,~~; or who have experienced a loss of in-home staffing support. Allowable activities and expenses for respite care services are defined under subdivision 4. A child is not required to have case management services to receive respite care services. Counties must work to provide access to regularly scheduled respite care;

(4) children's mental health crisis services;

(5) child-, youth-, and family-specific mobile response and stabilization services models;

(6) mental health services for people from cultural and ethnic minorities, including supervision of clinical trainees who are Black, indigenous, or people of color;

(7) children's mental health screening and follow-up diagnostic assessment and treatment;

(8) services to promote and develop the capacity of providers to use evidence-based practices in providing children's mental health services;

(9) school-linked mental health services under section 245.4901;

(10) building evidence-based mental health intervention capacity for children birth to age five;

(11) suicide prevention and counseling services that use text messaging statewide;

(12) mental health first aid training;

(13) training for parents, collaborative partners, and mental health providers on the impact of adverse childhood experiences and trauma and development of an interactive website to share information and strategies to promote resilience and prevent trauma;

(14) transition age services to develop or expand mental health treatment and supports for adolescents and young adults 26 years of age or younger;

(15) early childhood mental health consultation;

(16) evidence-based interventions for youth at risk of developing or experiencing a first episode of psychosis, and a public awareness campaign on the signs and symptoms of psychosis;

(17) psychiatric consultation for primary care practitioners; and

(18) providers to begin operations and meet program requirements when establishing a new children's mental health program. These may be start-up grants.

(c) Services under paragraph (b) must be designed to help each child to function and remain with the child's family in the community and delivered consistent with the child's treatment plan. Transition services to eligible young adults under this paragraph must be designed to foster independent living in the community.

(d) As a condition of receiving grant funds, a grantee shall obtain all available third-party reimbursement sources, if applicable.

(e) The commissioner may establish and design a pilot program to expand the mobile response and stabilization services model for children, youth, and families. The commissioner may use grant funding to consult with a qualified expert entity to assist in the formulation of measurable outcomes and explore and position the state to submit a Medicaid state plan amendment to scale the model statewide.

Sec. 41. Minnesota Statutes 2024, section 245.4907, subdivision 2, is amended to read:

Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider that employs a mental health certified peer family specialist qualified under section 245I.04, subdivision 12, and that provides services to families who have a child:

(1) with ~~an emotional disturbance~~ a mental illness or ~~severe emotional disturbance~~ serious mental illness under chapter 245;

(2) receiving inpatient hospitalization under section 256B.0625, subdivision 1;

(3) admitted to a residential treatment facility under section 245.4882;

(4) receiving children's intensive behavioral health services under section 256B.0946;

(5) receiving day treatment or children's therapeutic services and supports under section 256B.0943; or

(6) receiving crisis response services under section 256B.0624.

Sec. 42. Minnesota Statutes 2024, section 245.491, subdivision 2, is amended to read:

Subd. 2. **Purpose.** The legislature finds that children with mental illnesses or emotional or behavioral disturbances or who are at risk of suffering such disturbances often require services from multiple service systems including mental health, social services, education, corrections, juvenile court, health, and employment and economic development. In order to better meet the needs of these children, it is the intent of the legislature to establish an integrated children's mental health service system that:

(1) allows local service decision makers to draw funding from a single local source so that funds follow clients and eliminates the need to match clients, funds, services, and provider eligibilities;

(2) creates a local pool of state, local, and private funds to procure a greater medical assistance federal financial participation;

(3) improves the efficiency of use of existing resources;

(4) minimizes or eliminates the incentives for cost and risk shifting; and

(5) increases the incentives for earlier identification and intervention.

The children's mental health integrated fund established under sections 245.491 to 245.495 must be used to develop and support this integrated mental health service system. In developing this integrated service system, it is not the intent of the legislature to limit any rights available to children and their families through existing federal and state laws.

Sec. 43. Minnesota Statutes 2024, section 245.492, subdivision 3, is amended to read:

Subd. 3. **Children with emotional or behavioral disturbances.** "Children with emotional or behavioral disturbances" includes children with ~~emotional disturbances~~ mental illnesses as defined in section 245.4871, subdivision 15, and children with emotional or behavioral disorders as defined in Minnesota Rules, part 3525.1329, subpart 1.

Sec. 44. Minnesota Statutes 2024, section 245.697, subdivision 2a, is amended to read:

Subd. 2a. **Subcommittee on Children's Mental Health.** The State Advisory Council on Mental Health (the "advisory council") must have a Subcommittee on Children's Mental Health. The subcommittee must make recommendations to the advisory council on policies, laws, regulations, and services relating to children's mental health. Members of the subcommittee must include:

(1) the commissioners or designees of the commissioners of the Departments of Human Services, Health, Education, State Planning, and Corrections;

(2) a designee of the Direct Care and Treatment executive board;

(3) the commissioner of commerce or a designee of the commissioner who is knowledgeable about medical insurance issues;

(4) at least one representative of an advocacy group for children with ~~emotional disturbances~~ mental illnesses;

(5) providers of children's mental health services, including at least one provider of services to preadolescent children, one provider of services to adolescents, and one hospital-based provider;

(6) parents of children who have ~~emotional disturbances~~ mental illnesses;

(7) a present or former consumer of adolescent mental health services;

(8) educators currently working with ~~emotionally disturbed~~ children with mental illnesses;

(9) people knowledgeable about the needs of ~~emotionally disturbed~~ children with mental illnesses of minority races and cultures;

(10) people experienced in working with ~~emotionally disturbed~~ children with mental illnesses who have committed status offenses;

(11) members of the advisory council;

(12) one person from the local corrections department and one representative of the Minnesota District Judges Association Juvenile Committee; and

(13) county commissioners and social services agency representatives.

The chair of the advisory council shall appoint subcommittee members described in clauses (4) to (12) through the process established in section 15.0597. The chair shall appoint members to ensure a geographical balance on the subcommittee. Terms, compensation, removal, and filling of vacancies are governed by subdivision 1, except that terms of subcommittee members who are also members of the advisory council are coterminous with their terms on the advisory council. The subcommittee shall meet at the call of the subcommittee chair who is elected by the subcommittee from among its members. The subcommittee expires with the expiration of the advisory council.

Sec. 45. Minnesota Statutes 2024, section 245.814, subdivision 3, is amended to read:

Subd. 3. **Compensation provisions.** (a) If the commissioner of human services is unable to obtain insurance through ordinary methods for coverage of foster home providers, the appropriation shall be returned to the general fund and the state shall pay claims subject to the following limitations.

~~(a)~~ (b) Compensation shall be provided only for injuries, damage, or actions set forth in subdivision 1.

~~(b)~~ (c) Compensation shall be subject to the conditions and exclusions set forth in subdivision 2.

~~(c)~~ (d) The state shall provide compensation for bodily injury, property damage, or personal injury resulting from the foster home providers activities as a foster home provider while the foster child or adult is in the care, custody, and control of the foster home provider in an amount not to exceed $250,000 for each occurrence.

~~(d)~~ (e) The state shall provide compensation for damage or destruction of property caused or sustained by a foster child or adult in an amount not to exceed $250 for each occurrence.

~~(e)~~ (f) The compensation in paragraphs ~~(c) and~~ (d) and (e) is the total obligation for all damages because of each occurrence regardless of the number of claims made in connection with the same occurrence, but compensation applies separately to each foster home. The state shall have no other responsibility to provide compensation for any injury or loss caused or sustained by any foster home provider or foster child or foster adult.

(g) This coverage is extended as a benefit to foster home providers to encourage care of persons who need ~~out-of-home~~ the providers' care. Nothing in this section shall be construed to mean that foster home providers are agents or employees of the state nor does the state accept any responsibility for the selection, monitoring, supervision, or control of foster home providers which is exclusively the responsibility of the counties which shall regulate foster home providers in the manner set forth in the rules of the commissioner of human services.

Sec. 46. Minnesota Statutes 2024, section 245.826, is amended to read:

245.826 USE OF RESTRICTIVE TECHNIQUES AND PROCEDURES IN FACILITIES SERVING ~~EMOTIONALLY DISTURBED~~ CHILDREN WITH MENTAL ILLNESSES.

When amending rules governing facilities serving ~~emotionally disturbed~~ children with mental illnesses that are licensed under section 245A.09 and Minnesota Rules, parts 2960.0510 to 2960.0530 and 2960.0580 to 2960.0700, the commissioner of human services shall include provisions governing the use of restrictive techniques and procedures. No provision of these rules may encourage or require the use of restrictive techniques and procedures. The rules must prohibit: (1) the application of certain restrictive techniques or procedures in facilities, except as authorized in the child's case plan and monitored by the county caseworker responsible for the child; (2) the use of restrictive techniques or procedures that restrict the clients' normal access to nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary clothing; and (3) the use of corporal punishment. The rule may specify other restrictive techniques and procedures and the specific conditions under which permitted techniques and procedures are to be carried out.

Sec. 47. Minnesota Statutes 2024, section 245.91, subdivision 2, is amended to read:

Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state Departments of Human Services, Direct Care and Treatment, Health, and Education, and of local school districts and designated county social service agencies as defined in section 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~.

Sec. 48. Minnesota Statutes 2024, section 245.91, subdivision 4, is amended to read:

Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or residential program as defined in section 245A.02, subdivisions 10 and 14, and any agency, facility, or program that provides services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~ that is required to be licensed, certified, or registered by the commissioner of human services, health, or education; a sober home as defined in section 254B.01, subdivision 11; peer recovery support services provided by a recovery community organization as defined in section 254B.01, subdivision 8; and an acute care inpatient facility that provides services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~.

Sec. 49. Minnesota Statutes 2024, section 245.92, is amended to read:

245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS; FUNCTION.

The ombudsman for persons receiving services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~ shall promote the highest attainable standards of treatment, competence, efficiency, and justice. The ombudsman may gather information and data about decisions, acts, and other matters of an agency, facility, or program, and shall monitor the treatment of individuals participating in a University of Minnesota Department of Psychiatry clinical drug trial. The ombudsman is appointed by the governor, serves in the unclassified service, and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be a person who has knowledge and experience concerning the treatment, needs, and rights of clients, and who is highly competent and qualified. No person may serve as ombudsman while holding another public office.

Sec. 50. Minnesota Statutes 2024, section 245.94, subdivision 1, is amended to read:

Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which complaints to the office are to be made, reviewed, and acted upon. The ombudsman may not levy a complaint fee.

(b) The ombudsman is a health oversight agency as defined in Code of Federal Regulations, title 45, section 164.501. The ombudsman may access patient records according to Code of Federal Regulations, title 42, section 2.53. For purposes of this paragraph, "records" has the meaning given in Code of Federal Regulations, title 42, section 2.53(a)(1)(i).

(c) The ombudsman may mediate or advocate on behalf of a client.

(d) The ombudsman may investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients.

(e) At the request of a client, or upon receiving a complaint or other information affording reasonable grounds to believe that the rights of one or more clients who may not be capable of requesting assistance have been adversely affected, the ombudsman may gather information and data about and analyze, on behalf of the client, the actions of an agency, facility, or program.

(f) The ombudsman may gather, on behalf of one or more clients, records of an agency, facility, or program, or records related to clinical drug trials from the University of Minnesota Department of Psychiatry, if the records relate to a matter that is within the scope of the ombudsman's authority. If the records are private and the client is capable of providing consent, the ombudsman shall first obtain the client's consent. The ombudsman is not required to obtain consent for access to private data on clients with developmental

disabilities and individuals served by the Minnesota Sex Offender Program. The ombudsman may also take photographic or videographic evidence while reviewing the actions of an agency, facility, or program, with the consent of the client. The ombudsman is not required to obtain consent for access to private data on decedents who were receiving services for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~. All data collected, created, received, or maintained by the ombudsman are governed by chapter 13 and other applicable law.

(g) Notwithstanding any law to the contrary, the ombudsman may subpoena a person to appear, give testimony, or produce documents or other evidence that the ombudsman considers relevant to a matter under inquiry. The ombudsman may petition the appropriate court in Ramsey County to enforce the subpoena. A witness who is at a hearing or is part of an investigation possesses the same privileges that a witness possesses in the courts or under the law of this state. Data obtained from a person under this paragraph are private data as defined in section 13.02, subdivision 12.

(h) The ombudsman may, at reasonable times in the course of conducting a review, enter and view premises within the control of an agency, facility, or program.

(i) The ombudsman may attend Direct Care and Treatment Review Board and Special Review Board proceedings; proceedings regarding the transfer of clients, as defined in section 246.50, subdivision 4, between institutions operated by the Direct Care and Treatment executive board; and, subject to the consent of the affected client, other proceedings affecting the rights of clients. The ombudsman is not required to obtain consent to attend meetings or proceedings and have access to private data on clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program.

(j) The ombudsman shall gather data of agencies, facilities, or programs classified as private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding services provided to clients with developmental disabilities and individuals served by the Minnesota Sex Offender Program.

(k) To avoid duplication and preserve evidence, the ombudsman shall inform relevant licensing or regulatory officials before undertaking a review of an action of the facility or program.

(l) The Office of Ombudsman shall provide the services of the Civil Commitment Training and Resource Center.

(m) The ombudsman shall monitor the treatment of individuals participating in a University of Minnesota Department of Psychiatry clinical drug trial and ensure that all protections for human subjects required by federal law and the Institutional Review Board are provided.

(n) Sections 245.91 to 245.97 are in addition to other provisions of law under which any other remedy or right is provided.

Sec. 51. Minnesota Statutes 2024, 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 ~~emotional disturbance~~ 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.05 to provide care coordination and comprehensive assessment services;

(22) a recovery community organization that is an eligible vendor under section 254B.05 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. 52. Minnesota Statutes 2024, section 245A.26, subdivision 1, is amended to read:

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

(b) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "License holder" means an individual, organization, or government entity that was issued a license by the commissioner of human services under this chapter for residential mental health treatment for children with ~~emotional disturbance~~ mental illness according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700, or shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(d) "Mental health professional" means an individual who is qualified under section 245I.04, subdivision 2.

Sec. 53. Minnesota Statutes 2024, section 245A.26, subdivision 2, is amended to read:

Subd. 2. **Scope and applicability.** (a) This section establishes additional licensing requirements for a children's residential facility to provide children's residential crisis stabilization services to a client who is experiencing a mental health crisis and is in need of residential treatment services.

(b) A children's residential facility may provide residential crisis stabilization services only if the facility is licensed to provide:

(1) residential mental health treatment for children with ~~emotional disturbance~~ mental illness according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700; or

(2) shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510 to 2960.0530.

(c) If a client receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (1), the facility is not required to complete a diagnostic assessment or treatment plan under Minnesota Rules, part 2960.0180, subpart 2, and part 2960.0600.

(d) If a client receives residential crisis stabilization services for 35 days or fewer in a facility licensed according to paragraph (b), clause (2), the facility is not required to develop a plan for meeting the client's immediate needs under Minnesota Rules, part 2960.0520, subpart 3.

Sec. 54. Minnesota Statutes 2024, section 246C.12, subdivision 4, is amended to read:

Subd. 4. **Staff safety training.** The executive board shall require all staff in mental health and support units at regional treatment centers who have contact with ~~persons~~ children or adults with mental illness ~~or severe emotional disturbance~~ to be appropriately trained in violence reduction and violence prevention and shall establish criteria for such training. Training programs shall be developed with input from consumer advocacy organizations and shall employ violence prevention techniques as preferable to physical interaction.

Sec. 55. Minnesota Statutes 2024, section 252.27, subdivision 1, is amended to read:

Subdivision 1. **County of financial responsibility.** Whenever any child who has a developmental disability, or a physical disability or ~~emotional disturbance~~ mental illness is in 24-hour care outside the home including respite care, in a facility licensed by the commissioner of human services, the cost of services shall be paid by the county of financial responsibility determined pursuant to chapter 256G. If the child's parents or guardians do not reside in this state, the cost shall be paid by the responsible governmental agency in the state from which the child came, by the parents or guardians of the child if they are financially able, or, if no other payment source is available, by the commissioner of human services.

Sec. 56. Minnesota Statutes 2024, section 256B.02, subdivision 11, is amended to read:

Subd. 11. **Related condition.** "Related condition" means a condition:

(1) that is found to be closely related to a developmental disability, including but not limited to cerebral palsy, epilepsy, autism, fetal alcohol spectrum disorder, and Prader-Willi syndrome; and

(2) that meets all of the following criteria:

(i) is severe and chronic;

(ii) results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with developmental disabilities;

(iii) requires treatment or services similar to those required for persons with developmental disabilities;

(iv) is manifested before the person reaches 22 years of age;

(v) is likely to continue indefinitely;

(vi) results in substantial functional limitations in three or more of the following areas of major life activity:

(A) self-care;

(B) understanding and use of language;

(C) learning;

(D) mobility;

(E) self-direction; or

(F) capacity for independent living; and

(vii) is not attributable to mental illness as defined in section 245.462, subdivision 20, or ~~an emotional disturbance as defined in section~~ 245.4871, subdivision 15. For purposes of this item, notwithstanding section 245.462, subdivision 20, or 245.4871, subdivision 15, "mental illness" does not include autism or other pervasive developmental disorders.

Sec. 57. Minnesota Statutes 2024, section 256B.055, subdivision 12, is amended to read:

Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if the person is under age 19 and qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance under the state plan if residing in a medical institution, and the child requires a level of care provided in a hospital, nursing facility, or intermediate care facility for persons with developmental disabilities, for whom home care is appropriate, provided that the cost to medical assistance under this section is not more than the amount that medical assistance would pay for if the child resides in an institution. After the child is determined to be eligible under this section, the commissioner shall review the child's disability under United States Code, title 42, section 1382c(a) and level of care defined under this section no more often than annually and may elect, based on the recommendation of health care professionals under contract with the state medical review team, to extend the review of disability and level of care up to a maximum of four years. The commissioner's decision on the frequency of continuing review of disability and level of care is not subject to administrative appeal under section 256.045. The county agency shall send a notice of disability review to the enrollee six months prior to the date the recertification of disability is due. Nothing in this subdivision shall be construed as affecting other redeterminations of medical assistance eligibility under this chapter and annual cost-effective reviews under this section.

(b) For purposes of this subdivision, "hospital" means an institution as defined in section 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child requires a level of care provided in a hospital if the child is determined by the commissioner to need an extensive array of health services, including mental health services, for an undetermined period of time, whose health condition requires frequent monitoring and treatment by a health care professional or by a person supervised by a health care professional, who would reside in a hospital or require frequent hospitalization if these services were not provided, and the daily care needs are more complex than a nursing facility level of care.

A child with serious ~~emotional disturbance~~ mental illness requires a level of care provided in a hospital if the commissioner determines that the individual requires 24-hour supervision because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior, recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become life threatening, recurrent or frequent severe socially unacceptable behavior associated with psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic developmental problems requiring continuous skilled observation, or severe disabling symptoms for which office-centered outpatient treatment is not adequate, and which overall severely impact the individual's ability to function.

(c) For purposes of this subdivision, "nursing facility" means a facility which provides nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections 144A.02 to 144A.10, which is

appropriate if a person is in active restorative treatment; is in need of special treatments provided or supervised by a licensed nurse; or has unpredictable episodes of active disease processes requiring immediate judgment by a licensed nurse. For purposes of this subdivision, a child requires the level of care provided in a nursing facility if the child is determined by the commissioner to meet the requirements of the preadmission screening assessment document under section 256B.0911, adjusted to address age-appropriate standards for children age 18 and under.

(d) For purposes of this subdivision, "intermediate care facility for persons with developmental disabilities" or "ICF/DD" means a program licensed to provide services to persons with developmental disabilities under section 252.28, and chapter 245A, and a physical plant licensed as a supervised living facility under chapter 144, which together are certified by the Minnesota Department of Health as meeting the standards in Code of Federal Regulations, title 42, part 483, for an intermediate care facility which provides services for persons with developmental disabilities who require 24-hour supervision and active treatment for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child requires a level of care provided in an ICF/DD if the commissioner finds that the child has a developmental disability in accordance with section 256B.092, is in need of a 24-hour plan of care and active treatment similar to persons with developmental disabilities, and there is a reasonable indication that the child will need ICF/DD services.

(e) For purposes of this subdivision, a person requires the level of care provided in a nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental health treatment because of specific symptoms or functional impairments associated with a serious mental illness or disorder diagnosis, which meet severity criteria for mental health established by the commissioner and published in March 1997 as the Minnesota Mental Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

(f) The determination of the level of care needed by the child shall be made by the commissioner based on information supplied to the commissioner by (1) the parent or guardian, (2) the child's physician or physicians, advanced practice registered nurse or advanced practice registered nurses, or physician assistant or physician assistants, and (3) other professionals as requested by the commissioner. The commissioner shall establish a screening team to conduct the level of care determinations according to this subdivision.

(g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner must assess the case to determine whether:

(1) the child qualifies as a disabled individual under United States Code, title 42, section 1382c(a), and would be eligible for medical assistance if residing in a medical institution; and

(2) the cost of medical assistance services for the child, if eligible under this subdivision, would not be more than the cost to medical assistance if the child resides in a medical institution to be determined as follows:

(i) for a child who requires a level of care provided in an ICF/DD, the cost of care for the child in an institution shall be determined using the average payment rate established for the regional treatment centers that are certified as ICF's/DD;

(ii) for a child who requires a level of care provided in an inpatient hospital setting according to paragraph (b), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3520, items F and G; and

(iii) for a child who requires a level of care provided in a nursing facility according to paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules, part 9505.3040, except that the

nursing facility average rate shall be adjusted to reflect rates which would be paid for children under age 16. The commissioner may authorize an amount up to the amount medical assistance would pay for a child referred to the commissioner by the preadmission screening team under section 256B.0911.

Sec. 58. Minnesota Statutes 2024, section 256B.0616, subdivision 1, is amended to read:

Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer specialists services, as established in subdivision 2, subject to federal approval, if provided to recipients who have ~~an emotional disturbance~~ a mental illness or ~~severe emotional disturbance~~ serious mental illness under chapter 245, and are provided by a mental health certified family peer specialist who has completed the training under subdivision 5 and is qualified according to section 245I.04, subdivision 12. A family peer specialist cannot provide services to the peer specialist's family.

Sec. 59. Minnesota Statutes 2024, section 256B.0757, subdivision 2, is amended to read:

Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home models in accordance with United States Code, title 42, section 1396w-4.

(b) An individual is eligible for health home services under this section if the individual is eligible for medical assistance under this chapter and has a condition that meets the definition of mental illness as described in section 245.462, subdivision 20, paragraph (a), or ~~emotional disturbance as defined in section~~ 245.4871, subdivision 15, clause (2). The commissioner shall establish criteria for determining continued eligibility.

Sec. 60. Minnesota Statutes 2024, section 256B.0943, subdivision 1, is amended to read:

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

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed ~~emotional disturbance, as defined in section 245.4871, subdivision 15, or 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) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.~~

~~(j)~~ (i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

~~(k)~~ (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).

~~(l)~~ (k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

~~(m)~~ (l) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

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

~~(o)~~ (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.

~~(p)~~ (o) "Mental illness~~,~~" ~~for persons at least age 18 but under age 21,~~ 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.

~~(q)~~ (p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

~~(r)~~ (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.

~~(s)~~ (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).

~~(t)~~ (s) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

~~(u)~~ (t) "Treatment supervision" means the supervision described in section 245I.06.

Sec. 61. Minnesota Statutes 2024, 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 ~~emotional disturbance~~ mental illness or, if the person is between the ages of 18 and 21, whether the person has a mental illness;

(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. 62. Minnesota Statutes 2024, section 256B.0943, subdivision 9, is amended to read:

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a team under the treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884,

subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive it or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional, clinical trainee, or mental health practitioner must work with a group of three 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 ~~an emotional disturbance or~~ a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

Sec. 63. Minnesota Statutes 2024, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** 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 ~~emotional disturbance~~ 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.

Sec. 64. Minnesota Statutes 2024, section 256B.0943, subdivision 13, is amended to read:

Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15 hours of children's therapeutic services and supports provided within a six-month period to a child with ~~severe emotional disturbance~~ serious mental illness who is residing in a hospital; a residential treatment facility licensed under Minnesota Rules, parts 2960.0580 to 2960.0690; a psychiatric residential treatment facility under section 256B.0625, subdivision 45a; a regional treatment center; or other institutional group setting or who is participating in a program of partial hospitalization are eligible for medical assistance payment if part of the discharge plan.

Sec. 65. Minnesota Statutes 2024, section 256B.0945, subdivision 1, is amended to read:

Subdivision 1. **Residential services; provider qualifications.** (a) Counties must arrange to provide residential services for children with ~~severe emotional disturbance~~ serious mental illness according to sections 245.4882, 245.4885, and this section.

(b) Services must be provided by a facility that is licensed according to section 245.4882 and administrative rules promulgated thereunder, and under contract with the county.

(c) Eligible service costs may be claimed for a facility that is located in a state that borders Minnesota if:

(1) the facility is the closest facility to the child's home, providing the appropriate level of care; and

(2) the commissioner of human services has completed an inspection of the out-of-state program according to the interagency agreement with the commissioner of corrections under section 260B.198, subdivision 11, paragraph (b), and the program has been certified by the commissioner of corrections under section 260B.198, subdivision 11, paragraph (a), to substantially meet the standards applicable to children's residential mental health treatment programs under Minnesota Rules, chapter 2960. Nothing in this section requires the commissioner of human services to enforce the background study requirements under chapter 245C or the requirements related to prevention and investigation of alleged maltreatment under section 626.557 or chapter 260E. Complaints received by the commissioner of human services must be referred to the out-of-state licensing authority for possible follow-up.

(d) Notwithstanding paragraph (b), eligible service costs may be claimed for an out-of-state inpatient treatment facility if:

(1) the facility specializes in providing mental health services to children who are deaf, deafblind, or hard-of-hearing and who use American Sign Language as their first language;

(2) the facility is licensed by the state in which it is located; and

(3) the state in which the facility is located is a member state of the Interstate Compact on Mental Health.

Sec. 66. Minnesota Statutes 2024, section 256B.0946, subdivision 6, is amended to read:

Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this section and are not eligible for medical assistance payment as components of children's intensive behavioral health services, but may be billed separately:

(1) inpatient psychiatric hospital treatment;

(2) mental health targeted case management;

(3) partial hospitalization;

(4) medication management;

(5) children's mental health day treatment services;

(6) crisis response services under section 256B.0624;

(7) transportation; and

(8) mental health certified family peer specialist services under section 256B.0616.

(b) Children receiving intensive behavioral health services are not eligible for medical assistance reimbursement for the following services while receiving children's intensive behavioral health services:

(1) psychotherapy and skills training components of children's therapeutic services and supports under section 256B.0943;

(2) mental health behavioral aide services as defined in section 256B.0943, subdivision 1, paragraph ~~(l)~~ (j);

(3) home and community-based waiver services;

(4) mental health residential treatment; and

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

Sec. 67. Minnesota Statutes 2024, section 256B.0947, subdivision 3a, is amended to read:

Subd. 3a. **Required service components.** (a) Intensive nonresidential rehabilitative mental health services, supports, and ancillary activities that are covered by a single daily rate per client must include the following, as needed by the individual client:

(1) individual, family, and group psychotherapy;

(2) individual, family, and group skills training, as defined in section 256B.0943, subdivision 1, paragraph ~~(u)~~ (r);

(3) crisis planning as defined in section 245.4871, subdivision 9a;

(4) medication management provided by a physician, an advanced practice registered nurse with certification in psychiatric and mental health care, or a physician assistant;

(5) mental health case management as provided in section 256B.0625, subdivision 20;

(6) medication education services as defined in this section;

(7) care coordination by a client-specific lead worker assigned by and responsible to the treatment team;

(8) psychoeducation of and consultation and coordination with the client's biological, adoptive, or foster family and, in the case of a youth living independently, the client's immediate nonfamilial support network;

(9) clinical consultation to a client's employer or school or to other service agencies or to the courts to assist in managing the mental illness or co-occurring disorder and to develop client support systems;

(10) coordination with, or performance of, crisis intervention and stabilization services as defined in section 256B.0624;

(11) transition services;

(12) co-occurring substance use disorder treatment as defined in section 245I.02, subdivision 11; and

(13) housing access support that assists clients to find, obtain, retain, and move to safe and adequate housing. Housing access support does not provide monetary assistance for rent, damage deposits, or application fees.

(b) The provider shall ensure and document the following by means of performing the required function or by contracting with a qualified person or entity: client access to crisis intervention services, as defined in section 256B.0624, and available 24 hours per day and seven days per week.

Sec. 68. Minnesota Statutes 2024, section 256B.69, subdivision 23, is amended to read:

Subd. 23. **Alternative services; elderly persons and persons with a disability.** (a) The commissioner may implement demonstration projects to create alternative integrated delivery systems for acute and long-term care services to elderly persons and persons with disabilities as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve access to quality services, and mitigate future cost increases. The commissioner may seek federal authority to combine Medicare and Medicaid capitation payments for the purpose of such demonstrations and may contract with Medicare-approved special needs plans that are offered by a demonstration provider or by an entity that is directly or indirectly wholly owned or controlled by a demonstration provider to provide Medicaid services. Medicare funds and services shall be administered according to the terms and conditions of the federal contract and demonstration provisions. For the purpose of administering medical assistance funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations, with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items B and C, which do not apply to persons enrolling in demonstrations under this section. All enforcement and rulemaking powers available under chapters 62D, 62M, and 62Q are hereby granted to the commissioner of health with respect to Medicare-approved special needs plans with which the commissioner contracts to provide Medicaid services under this section. An initial open enrollment period may be provided. Persons who disenroll from demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and the health plan's participation is subsequently terminated for any reason, the person shall be provided an opportunity to select a new health plan and shall have the right to change health plans within the first 60 days of enrollment in the second health plan. Persons required to participate in health plans under this section who fail to make a choice of health plan shall not be randomly assigned to health plans under these demonstrations.

Notwithstanding section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A, if adopted, for the purpose of demonstrations under this subdivision, the commissioner may contract with managed care organizations, including counties, to serve only elderly persons eligible for medical assistance, elderly persons with a disability, or persons with a disability only. For persons with a primary diagnosis of developmental disability, serious and persistent mental illness, or serious ~~emotional disturbance~~ mental illness in children, the commissioner must ensure that the county authority has approved the demonstration and contracting design. Enrollment in these projects for persons with disabilities shall be voluntary. The commissioner shall not implement any demonstration project under this subdivision for persons with a primary diagnosis of developmental disabilities, serious and persistent mental illness, or serious ~~emotional disturbance,~~ mental illness in children without approval of the county board of the county in which the demonstration is being implemented.

(b) MS 2009 Supplement [Expired, 2003 c 47 s 4; 2007 c 147 art 7 s 60]

(c) Before implementation of a demonstration project for persons with a disability, the commissioner must provide information to appropriate committees of the house of representatives and senate and must involve representatives of affected disability groups in the design of the demonstration projects.

(d) A nursing facility reimbursed under the alternative reimbursement methodology in section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity provide services under paragraph (a). The commissioner shall amend the state plan and seek any federal waivers necessary to implement this paragraph.

(e) The commissioner, in consultation with the commissioners of commerce and health, may approve and implement programs for all-inclusive care for the elderly (PACE) according to federal laws and regulations governing that program and state laws or rules applicable to participating providers. A PACE provider is not required to be licensed or certified as a health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older who have been screened by the county and found to be eligible for services under the elderly waiver or community access for disability inclusion or who are already eligible for Medicaid but meet level of care criteria for receipt of waiver services may choose to enroll in the PACE program. Medicare and Medicaid services will be provided according to this subdivision and federal Medicare and Medicaid requirements governing PACE providers and programs. PACE enrollees will receive Medicaid home and community-based services through the PACE provider as an alternative to services for which they would otherwise be eligible through home and community-based waiver programs and Medicaid State Plan Services. The commissioner shall establish Medicaid rates for PACE providers that do not exceed costs that would have been incurred under fee-for-service or other relevant managed care programs operated by the state.

(f) The commissioner shall seek federal approval to expand the Minnesota disability health options (MnDHO) program established under this subdivision in stages, first to regional population centers outside the seven-county metro area and then to all areas of the state. Until July 1, 2009, expansion for MnDHO projects that include home and community-based services is limited to the two projects and service areas in effect on March 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based services shall remain voluntary. Costs for home and community-based services included under MnDHO must not exceed costs that would have been incurred under the fee-for-service program. Notwithstanding whether expansion occurs under this paragraph, in determining MnDHO payment rates and risk adjustment methods, the commissioner must consider the methods used to determine county allocations for home and community-based program participants. If necessary to reduce MnDHO rates to comply with the provision regarding MnDHO costs for home and community-based services, the commissioner shall achieve the reduction by maintaining the base rate for contract year 2010 for services provided under the community

access for disability inclusion waiver at the same level as for contract year 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases in provider payment rates required by state law. Effective January 1, 2011, enrollment and operation of the MnDHO program in effect during 2010 shall cease. The commissioner may reopen the program provided all applicable conditions of this section are met. In developing program specifications for expansion of integrated programs, the commissioner shall involve and consult the state-level stakeholder group established in subdivision 28, paragraph (d), including consultation on whether and how to include home and community-based waiver programs. Plans to reopen MnDHO projects shall be presented to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance prior to implementation.

(g) Notwithstanding section 256B.0621, health plans providing services under this section are responsible for home care targeted case management and relocation targeted case management. Services must be provided according to the terms of the waivers and contracts approved by the federal government.

Sec. 69. Minnesota Statutes 2024, section 256B.77, subdivision 7a, is amended to read:

Subd. 7a. **Eligible individuals.** (a) Persons are eligible for the demonstration project as provided in this subdivision.

(b) "Eligible individuals" means those persons living in the demonstration site who are eligible for medical assistance and are disabled based on a disability determination under section 256B.055, subdivisions 7 and 12, or who are eligible for medical assistance and have been diagnosed as having:

(1) serious and persistent mental illness as defined in section 245.462, subdivision 20;

(2) ~~severe emotional disturbance~~ serious mental illness as defined in section 245.4871, subdivision 6; or

(3) developmental disability, or being a person with a developmental disability as defined in section 252A.02, or a related condition as defined in section 256B.02, subdivision 11.

Other individuals may be included at the option of the county authority based on agreement with the commissioner.

(c) Eligible individuals include individuals in excluded time status, as defined in chapter 256G. Enrollees in excluded time at the time of enrollment shall remain in excluded time status as long as they live in the demonstration site and shall be eligible for 90 days after placement outside the demonstration site if they move to excluded time status in a county within Minnesota other than their county of financial responsibility.

(d) A person who is a sexual psychopathic personality as defined in section 253D.02, subdivision 15, or a sexually dangerous person as defined in section 253D.02, subdivision 16, is excluded from enrollment in the demonstration project.

Sec. 70. Minnesota Statutes 2024, section 260B.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The local social services agency shall establish a juvenile treatment screening team to conduct screenings and prepare case plans under this subdivision. The team, which may be the team constituted under section 245.4885 or 256B.092 or chapter 254B, shall consist of social workers, juvenile justice professionals, and persons with expertise in the treatment of juveniles who are emotionally disabled, chemically dependent, or have a developmental disability. The team shall

involve parents or guardians in the screening process as appropriate. The team may be the same team as defined in section 260C.157, subdivision 3.

(b) If the court, prior to~~,~~ or as part of~~,~~ a final disposition, proposes to place a child:

(1) for the primary purpose of treatment for ~~an emotional disturbance~~ mental illness, and residential placement is consistent with section 260.012, a developmental disability, or chemical dependency in a residential treatment facility out of state or in one which is within the state and licensed by the commissioner of human services under chapter 245A; or

(2) in any out-of-home setting potentially exceeding 30 days in duration, including a post-dispositional placement in a facility licensed by the commissioner of corrections or human services, the court shall notify the county welfare agency. The county's juvenile treatment screening team must either:

(i) screen and evaluate the child and file its recommendations with the court within 14 days of receipt of the notice; or

(ii) elect not to screen a given case, and notify the court of that decision within three working days.

(c) If the screening team has elected to screen and evaluate the child, the child may not be placed for the primary purpose of treatment for ~~an emotional disturbance~~ mental illness, a developmental disability, or chemical dependency, in a residential treatment facility out of state nor in a residential treatment facility within the state that is licensed under chapter 245A, unless one of the following conditions applies:

(1) a treatment professional certifies that an emergency requires the placement of the child in a facility within the state;

(2) the screening team has evaluated the child and recommended that a residential placement is necessary to meet the child's treatment needs and the safety needs of the community, that it is a cost-effective means of meeting the treatment needs, and that it will be of therapeutic value to the child; or

(3) the court, having reviewed a screening team recommendation against placement, determines to the contrary that a residential placement is necessary. The court shall state the reasons for its determination in writing, on the record, and shall respond specifically to the findings and recommendation of the screening team in explaining why the recommendation was rejected. The attorney representing the child and the prosecuting attorney shall be afforded an opportunity to be heard on the matter.

Sec. 71. Minnesota Statutes 2024, section 260C.007, subdivision 16, is amended to read:

Subd. 16. **~~Emotionally disturbed~~ Mental illness.** "~~Emotionally disturbed~~ Mental illness" ~~means emotional disturbance as described~~ has the meaning given in section 245.4871, subdivision 15.

Sec. 72. Minnesota Statutes 2024, section 260C.007, subdivision 26d, is amended to read:

Subd. 26d. **Qualified residential treatment program.** "Qualified residential treatment program" means a children's residential treatment program licensed under chapter 245A or licensed or approved by a tribe that is approved to receive foster care maintenance payments under section 142A.418 that:

(1) has a trauma-informed treatment model designed to address the needs of children with serious emotional or behavioral disorders or disturbances or mental illnesses;

(2) has registered or licensed nursing staff and other licensed clinical staff who:

(i) provide care within the scope of their practice; and

(ii) are available 24 hours per day and seven days per week;

(3) is accredited by any of the following independent, nonprofit organizations: the Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the Council on Accreditation (COA), or any other nonprofit accrediting organization approved by the United States Department of Health and Human Services;

(4) if it is in the child's best interests, facilitates participation of the child's family members in the child's treatment programming consistent with the child's out-of-home placement plan under sections 260C.212, subdivision 1, and 260C.708;

(5) facilitates outreach to family members of the child, including siblings;

(6) documents how the facility facilitates outreach to the child's parents and relatives, as well as documents the child's parents' and other relatives' contact information;

(7) documents how the facility includes family members in the child's treatment process, including after the child's discharge, and how the facility maintains the child's sibling connections; and

(8) provides the child and child's family with discharge planning and family-based aftercare support for at least six months after the child's discharge. Aftercare support may include clinical care consultation under section 256B.0671, subdivision 7, and mental health certified family peer specialist services under section 256B.0616.

Sec. 73. Minnesota Statutes 2024, section 260C.007, subdivision 27b, is amended to read:

Subd. 27b. **Residential treatment facility.** "Residential treatment facility" means a 24-hour-a-day program that provides treatment for children with ~~emotional disturbance~~ mental illness, consistent with section 245.4871, subdivision 32, and includes a licensed residential program specializing in caring 24 hours a day for children with a developmental delay or related condition. A residential treatment facility does not include a psychiatric residential treatment facility under section 256B.0941 or a family foster home as defined in section 260C.007, subdivision 16b.

Sec. 74. Minnesota Statutes 2024, section 260C.157, subdivision 3, is amended to read:

Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency shall establish a juvenile treatment screening team to conduct screenings under this chapter and chapter 260D, for a child to receive treatment for ~~an emotional disturbance~~ a mental illness, ~~a~~ developmental disability, or related condition in a residential treatment facility licensed by the commissioner of human services under chapter 245A, or licensed or approved by a tribe. A screening team is not required for a child to be in: (1) a residential facility specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in high-quality residential care and supportive services to children and youth who have been or are at risk of becoming victims of sex trafficking or commercial sexual exploitation; (3) supervised settings for youth who are 18 years of age or older and living independently; or (4) a licensed residential family-based treatment facility for substance abuse consistent with section 260C.190. Screenings are also not required when a child must be placed in a facility due to an emotional crisis or other mental health emergency.

(b) The responsible social services agency shall conduct screenings within 15 days of a request for a screening, unless the screening is for the purpose of residential treatment and the child is enrolled in a prepaid

health program under section 256B.69, in which case the agency shall conduct the screening within ten working days of a request. The responsible social services agency shall convene the juvenile treatment screening team, which may be constituted under section 245.4885, 254B.05, or 256B.092. The team shall consist of social workers; persons with expertise in the treatment of juveniles who are emotionally disturbed, chemically dependent, or have a developmental disability; and the child's parent, guardian, or permanent legal custodian. The team may include the child's relatives as defined in section 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who are a resource to the child's family such as teachers, medical or mental health providers, and clergy, as appropriate, consistent with the family and permanency team as defined in section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services agency must consult with the child's parents, the child if the child is age 14 or older, and, if applicable, the child's tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals. This provision does not apply to paragraph (c).

(c) If the agency provides notice to tribes under section 260.761, and the child screened is an Indian child, the responsible social services agency must make a rigorous and concerted effort to include a designated representative of the Indian child's tribe on the juvenile treatment screening team, unless the child's tribal authority declines to appoint a representative. The Indian child's tribe may delegate its authority to represent the child to any other federally recognized Indian tribe, as defined in section 260.755, subdivision 12. The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to 260.835, apply to this section.

(d) If the court, prior to, or as part of, a final disposition or other court order, proposes to place a child with ~~an emotional disturbance or~~ a mental illness, developmental disability, or related condition in residential treatment, the responsible social services agency must conduct a screening. If the team recommends treating the child in a qualified residential treatment program, the agency must follow the requirements of sections 260C.70 to 260C.714.

The court shall ascertain whether the child is an Indian child and shall notify the responsible social services agency and, if the child is an Indian child, shall notify the Indian child's tribe as paragraph (c) requires.

(e) When the responsible social services agency is responsible for placing and caring for the child and the screening team recommends placing a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, the agency must: (1) begin the assessment and processes required in section 260C.704 without delay; and (2) conduct a relative search according to section 260C.221 to assemble the child's family and permanency team under section 260C.706. Prior to notifying relatives regarding the family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is age 14 or older, and, if applicable, the child's tribe to ensure that the agency is providing notice to individuals who will act in the child's best interests. The child and the child's parents may identify a culturally competent qualified individual to complete the child's assessment. The agency shall make efforts to refer the assessment to the identified qualified individual. The assessment may not be delayed for the purpose of having the assessment completed by a specific qualified individual.

(f) When a screening team determines that a child does not need treatment in a qualified residential treatment program, the screening team must:

(1) document the services and supports that will prevent the child's foster care placement and will support the child remaining at home;

(2) document the services and supports that the agency will arrange to place the child in a family foster home; or

(3) document the services and supports that the agency has provided in any other setting.

(g) When the Indian child's tribe or tribal health care services provider or Indian Health Services provider proposes to place a child for the primary purpose of treatment for ~~an emotional disturbance~~ a mental illness, a developmental disability, or co-occurring ~~emotional disturbance~~ mental illness and chemical dependency, the Indian child's tribe or the tribe delegated by the child's tribe shall submit necessary documentation to the county juvenile treatment screening team, which must invite the Indian child's tribe to designate a representative to the screening team.

(h) The responsible social services agency must conduct and document the screening in a format approved by the commissioner of human services.

Sec. 75. Minnesota Statutes 2024, section 260C.201, subdivision 1, is amended to read:

Subdivision 1. **Dispositions.** (a) If the court finds that the child is in need of protection or services or neglected and in foster care, the court shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the responsible social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, the father must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in the father's home; and

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2; or

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the responsible social services agency. In making a foster care placement of a child whose custody has been transferred under this subdivision, the agency shall make an individualized determination of how the placement is in the child's best interests using the placement consideration order for relatives and the best interest factors in section 260C.212, subdivision 2, and may include a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190; or

(3) order a trial home visit without modifying the transfer of legal custody to the responsible social services agency under clause (2). Trial home visit means the child is returned to the care of the parent or guardian from whom the child was removed for a period not to exceed six months. During the period of the trial home visit, the responsible social services agency:

(i) shall continue to have legal custody of the child, which means that the agency may see the child in the parent's home, at school, in a child care facility, or other setting as the agency deems necessary and appropriate;

(ii) shall continue to have the ability to access information under section 260C.208;

(iii) shall continue to provide appropriate services to both the parent and the child during the period of the trial home visit;

(iv) without previous court order or authorization, may terminate the trial home visit in order to protect the child's health, safety, or welfare and may remove the child to foster care;

(v) shall advise the court and parties within three days of the termination of the trial home visit when a visit is terminated by the responsible social services agency without a court order; and

(vi) shall prepare a report for the court when the trial home visit is terminated whether by the agency or court order that describes the child's circumstances during the trial home visit and recommends appropriate orders, if any, for the court to enter to provide for the child's safety and stability. In the event a trial home visit is terminated by the agency by removing the child to foster care without prior court order or authorization, the court shall conduct a hearing within ten days of receiving notice of the termination of the trial home visit by the agency and shall order disposition under this subdivision or commence permanency proceedings under sections 260C.503 to 260C.515. The time period for the hearing may be extended by the court for good cause shown and if it is in the best interests of the child as long as the total time the child spends in foster care without a permanency hearing does not exceed 12 months;

(4) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a physical or mental disability or ~~emotional disturbance~~ a mental illness as defined in section 245.4871, subdivision 15, the court may order the child's parent, guardian, or custodian to provide it. The court may order the child's health plan company to provide mental health services to the child. Section 62Q.535 applies to an order for mental health services directed to the child's health plan company. If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

(5) if the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and

the conduct of the parents, guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to $100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child or of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but in no event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction

if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child as defined in paragraph (f).

(e) When a parent has complied with a case plan ordered under subdivision 6 and the child is in the care of the parent, the court may order the responsible social services agency to monitor the parent's continued ability to maintain the child safely in the home under such terms and conditions as the court determines appropriate under the circumstances.

(f) For the purposes of this subdivision, "alternative safe living arrangement" means a living arrangement for a child proposed by a petitioning parent or guardian if a court excludes the minor from the parent's or guardian's home that is separate from the victim of domestic abuse and safe for the child respondent. A living arrangement proposed by a petitioning parent or guardian is presumed to be an alternative safe living arrangement absent information to the contrary presented to the court. In evaluating any proposed living arrangement, the court shall consider whether the arrangement provides the child with necessary food, clothing, shelter, and education in a safe environment. Any proposed living arrangement that would place the child in the care of an adult who has been physically or sexually violent is presumed unsafe.

Sec. 76. Minnesota Statutes 2024, section 260C.201, subdivision 2, is amended to read:

Subd. 2. **Written findings.** (a) Any order for a disposition authorized under this section shall contain written findings of fact to support the disposition and case plan ordered and shall also set forth in writing the following information:

(1) why the best interests and safety of the child are served by the disposition and case plan ordered;

(2) what alternative dispositions or services under the case plan were considered by the court and why such dispositions or services were not appropriate in the instant case;

(3) when legal custody of the child is transferred, the appropriateness of the particular placement made or to be made by the placing agency using the relative and sibling placement considerations and best interest factors in section 260C.212, subdivision 2, or the appropriateness of a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190;

(4) whether reasonable efforts to finalize the permanent plan for the child consistent with section 260.012 were made including reasonable efforts:

(i) to prevent the child's placement and to reunify the child with the parent or guardian from whom the child was removed at the earliest time consistent with the child's safety. The court's findings must include a brief description of what preventive and reunification efforts were made and why further efforts could not have prevented or eliminated the necessity of removal or that reasonable efforts were not required under section 260.012 or 260C.178, subdivision 1;

(ii) to identify and locate any noncustodial or nonresident parent of the child and to assess such parent's ability to provide day-to-day care of the child, and, where appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide day-to-day care of the child as required under section 260C.219, unless such services are not required under section 260.012 or 260C.178, subdivision 1. The court's findings must include a description of the agency's efforts to:

(A) identify and locate the child's noncustodial or nonresident parent;

(B) assess the noncustodial or nonresident parent's ability to provide day-to-day care of the child; and

(C) if appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide the child's day-to-day care, including efforts to engage the noncustodial or nonresident parent in assuming care and responsibility of the child;

(iii) to make the diligent search for relatives and provide the notices required under section 260C.221; a finding made pursuant to a hearing under section 260C.202 that the agency has made diligent efforts to conduct a relative search and has appropriately engaged relatives who responded to the notice under section 260C.221 and other relatives, who came to the attention of the agency after notice under section 260C.221 was sent, in placement and case planning decisions fulfills the requirement of this item;

(iv) to identify and make a foster care placement of the child, considering the order in section 260C.212, subdivision 2, paragraph (a), in the home of an unlicensed relative, according to the requirements of section 142B.06, a licensed relative, or other licensed foster care provider, who will commit to being the permanent legal parent or custodian for the child in the event reunification cannot occur, but who will actively support the reunification plan for the child. If the court finds that the agency has not appropriately considered relatives for placement of the child, the court shall order the agency to comply with section 260C.212, subdivision 2, paragraph (a). The court may order the agency to continue considering relatives for placement of the child regardless of the child's current placement setting; and

(v) to place siblings together in the same home or to ensure visitation is occurring when siblings are separated in foster care placement and visitation is in the siblings' best interests under section 260C.212, subdivision 2, paragraph (d); and

(5) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a mental disability or ~~emotional disturbance~~ a mental illness as defined in section 245.4871, subdivision 15, the written findings shall also set forth:

(i) whether the child has mental health needs that must be addressed by the case plan;

(ii) what consideration was given to the diagnostic and functional assessments performed by the child's mental health professional and to health and mental health care professionals' treatment recommendations;

(iii) what consideration was given to the requests or preferences of the child's parent or guardian with regard to the child's interventions, services, or treatment; and

(iv) what consideration was given to the cultural appropriateness of the child's treatment or services.

(b) If the court finds that the social services agency's preventive or reunification efforts have not been reasonable but that further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(c) If the child has been identified by the responsible social services agency as the subject of concurrent permanency planning, the court shall review the reasonable efforts of the agency to develop a permanency plan for the child that includes a primary plan that is for reunification with the child's parent or guardian and a secondary plan that is for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner.

Sec. 77. Minnesota Statutes 2024, section 260C.301, subdivision 4, is amended to read:

Subd. 4. **Current foster care children.** Except for cases where the child is in placement due solely to the child's developmental disability or ~~emotional disturbance~~ a mental illness, where custody has not been transferred to the responsible social services agency, and where the court finds compelling reasons to continue

placement, the county attorney shall file a termination of parental rights petition or a petition to transfer permanent legal and physical custody to a relative under section 260C.515, subdivision 4, for all children who have been in out-of-home care for 15 of the most recent 22 months. This requirement does not apply if there is a compelling reason approved by the court for determining that filing a termination of parental rights petition or other permanency petition would not be in the best interests of the child or if the responsible social services agency has not provided reasonable efforts necessary for the safe return of the child, if reasonable efforts are required.

Sec. 78. Minnesota Statutes 2024, section 260D.01, is amended to read:

260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

(a) Sections 260D.01 to 260D.10, may be cited as the "child in voluntary foster care for treatment" provisions of the Juvenile Court Act.

(b) The juvenile court has original and exclusive jurisdiction over a child in voluntary foster care for treatment upon the filing of a report or petition required under this chapter. All obligations of the responsible social services agency to a child and family in foster care contained in chapter 260C not inconsistent with this chapter are also obligations of the agency with regard to a child in foster care for treatment under this chapter.

(c) This chapter shall be construed consistently with the mission of the children's mental health service system as set out in section 245.487, subdivision 3, and the duties of an agency under sections 256B.092 and 260C.157 and Minnesota Rules, parts 9525.0004 to 9525.0016, to meet the needs of a child with a developmental disability or related condition. This chapter:

(1) establishes voluntary foster care through a voluntary foster care agreement as the means for an agency and a parent to provide needed treatment when the child must be in foster care to receive necessary treatment for ~~an emotional disturbance or~~ a mental illness, developmental disability, or related condition;

(2) establishes court review requirements for a child in voluntary foster care for treatment due to ~~emotional disturbance or~~ a mental illness, developmental disability, or ~~a~~ related condition;

(3) establishes the ongoing responsibility of the parent as legal custodian to visit the child, to plan together with the agency for the child's treatment needs, to be available and accessible to the agency to make treatment decisions, and to obtain necessary medical, dental, and other care for the child;

(4) applies to voluntary foster care when the child's parent and the agency agree that the child's treatment needs require foster care either:

(i) due to a level of care determination by the agency's screening team informed by the child's diagnostic and functional assessment under section 245.4885; or

(ii) due to a determination regarding the level of services needed by the child by the responsible social services agency's screening team under section 256B.092, and Minnesota Rules, parts 9525.0004 to 9525.0016; and

(5) includes the requirements for a child's placement in sections 260C.70 to 260C.714, when the juvenile treatment screening team recommends placing a child in a qualified residential treatment program, except as modified by this chapter.

(d) This chapter does not apply when there is a current determination under chapter 260E that the child requires child protective services or when the child is in foster care for any reason other than treatment for the child's ~~emotional disturbance or~~ mental illness, developmental disability, or related condition. When there is a determination under chapter 260E that the child requires child protective services based on an assessment that there are safety and risk issues for the child that have not been mitigated through the parent's engagement in services or otherwise, or when the child is in foster care for any reason other than the child's ~~emotional disturbance or~~ mental illness, developmental disability, or related condition, the provisions of chapter 260C apply.

(e) The paramount consideration in all proceedings concerning a child in voluntary foster care for treatment is the safety, health, and the best interests of the child. The purpose of this chapter is:

(1) to ensure that a child with a disability is provided the services necessary to treat or ameliorate the symptoms of the child's disability;

(2) to preserve and strengthen the child's family ties whenever possible and in the child's best interests, approving the child's placement away from the child's parents only when the child's need for care or treatment requires out-of-home placement and the child cannot be maintained in the home of the parent; and

(3) to ensure that the child's parent retains legal custody of the child and associated decision-making authority unless the child's parent willfully fails or is unable to make decisions that meet the child's safety, health, and best interests. The court may not find that the parent willfully fails or is unable to make decisions that meet the child's needs solely because the parent disagrees with the agency's choice of foster care facility, unless the agency files a petition under chapter 260C, and establishes by clear and convincing evidence that the child is in need of protection or services.

(f) The legal parent-child relationship shall be supported under this chapter by maintaining the parent's legal authority and responsibility for ongoing planning for the child and by the agency's assisting the parent, when necessary, to exercise the parent's ongoing right and obligation to visit or to have reasonable contact with the child. Ongoing planning means:

(1) actively participating in the planning and provision of educational services, medical, and dental care for the child;

(2) actively planning and participating with the agency and the foster care facility for the child's treatment needs;

(3) planning to meet the child's need for safety, stability, and permanency, and the child's need to stay connected to the child's family and community;

(4) engaging with the responsible social services agency to ensure that the family and permanency team under section 260C.706 consists of appropriate family members. For purposes of voluntary placement of a child in foster care for treatment under chapter 260D, prior to forming the child's family and permanency team, the responsible social services agency must consult with the child's parent or legal guardian, the child if the child is 14 years of age or older, and, if applicable, the child's Tribe to obtain recommendations regarding which individuals to include on the team and to ensure that the team is family-centered and will act in the child's best interests. If the child, child's parents, or legal guardians raise concerns about specific relatives or professionals, the team should not include those individuals unless the individual is a treating professional or an important connection to the youth as outlined in the case or crisis plan; and

(5) for a voluntary placement under this chapter in a qualified residential treatment program, as defined in section 260C.007, subdivision 26d, for purposes of engaging in a relative search as provided in section

260C.221, the county agency must consult with the child's parent or legal guardian, the child if the child is 14 years of age or older, and, if applicable, the child's Tribe to obtain recommendations regarding which adult relatives the county agency should notify. If the child, child's parents, or legal guardians raise concerns about specific relatives, the county agency should not notify those relatives.

(g) The provisions of section 260.012 to ensure placement prevention, family reunification, and all active and reasonable effort requirements of that section apply.

Sec. 79. Minnesota Statutes 2024, section 260D.02, subdivision 5, is amended to read:

Subd. 5. **Child in voluntary foster care for treatment.** "Child in voluntary foster care for treatment" means a child with ~~emotional disturbance~~ a mental illness or developmental disability~~,~~ or who has a related condition and is in foster care under a voluntary foster care agreement between the child's parent and the agency due to concurrence between the agency and the parent when it is determined that foster care is medically necessary:

(1) due to a determination by the agency's screening team based on its review of the diagnostic and functional assessment under section 245.4885; or

(2) due to a determination by the agency's screening team under section 256B.092 and Minnesota Rules, parts 9525.0004 to 9525.0016.

A child is not in voluntary foster care for treatment under this chapter when there is a current determination under chapter 260E that the child requires child protective services or when the child is in foster care for any reason other than the child's ~~emotional or~~ mental illness, developmental disability, or related condition.

Sec. 80. Minnesota Statutes 2024, section 260D.02, subdivision 9, is amended to read:

Subd. 9. **~~Emotional disturbance~~ Mental illness.** "~~Emotional disturbance~~ Mental illness" ~~means emotional disturbance as described~~ has the meaning given in section 245.4871, subdivision 15.

Sec. 81. Minnesota Statutes 2024, section 260D.03, subdivision 1, is amended to read:

Subdivision 1. **Voluntary foster care.** When the agency's screening team, based upon the diagnostic and functional assessment under section 245.4885 or medical necessity screenings under section 256B.092, subdivision 7, determines the child's need for treatment due to ~~emotional disturbance or~~ a mental illness, developmental disability, or related condition requires foster care placement of the child, a voluntary foster care agreement between the child's parent and the agency gives the agency legal authority to place the child in foster care.

Sec. 82. Minnesota Statutes 2024, section 260D.04, is amended to read:

260D.04 REQUIRED INFORMATION FOR A CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.

An agency with authority to place a child in voluntary foster care for treatment due to ~~emotional disturbance or~~ a mental illness, developmental disability, or related condition~~,~~ shall inform the child, age 12 or older, of the following:

(1) the child has the right to be consulted in the preparation of the out-of-home placement plan required under section 260C.212, subdivision 1, and the administrative review required under section 260C.203;

(2) the child has the right to visit the parent and the right to visit the child's siblings as determined safe and appropriate by the parent and the agency;

(3) if the child disagrees with the foster care facility or services provided under the out-of-home placement plan required under section 260C.212, subdivision 1, the agency shall include information about the nature of the child's disagreement and, to the extent possible, the agency's understanding of the basis of the child's disagreement in the information provided to the court in the report required under section 260D.06; and

(4) the child has the rights established under Minnesota Rules, part 2960.0050, as a resident of a facility licensed by the state.

Sec. 83. Minnesota Statutes 2024, section 260D.06, subdivision 2, is amended to read:

Subd. 2. **Agency report to court; court review.** The agency shall obtain judicial review by reporting to the court according to the following procedures:

(a) A written report shall be forwarded to the court within 165 days of the date of the voluntary placement agreement. The written report shall contain or have attached:

(1) a statement of facts that necessitate the child's foster care placement;

(2) the child's name, date of birth, race, gender, and current address;

(3) the names, race, date of birth, residence, and post office addresses of the child's parents or legal custodian;

(4) a statement regarding the child's eligibility for membership or enrollment in an Indian tribe and the agency's compliance with applicable provisions of sections 260.751 to 260.835;

(5) the names and addresses of the foster parents or chief administrator of the facility in which the child is placed, if the child is not in a family foster home or group home;

(6) a copy of the out-of-home placement plan required under section 260C.212, subdivision 1;

(7) a written summary of the proceedings of any administrative review required under section 260C.203;

(8) evidence as specified in section 260C.712 when a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d; and

(9) any other information the agency, parent or legal custodian, the child or the foster parent, or other residential facility wants the court to consider.

(b) In the case of a child in placement due to ~~emotional disturbance~~ a mental illness, the written report shall include as an attachment, the child's individual treatment plan developed by the child's treatment professional, as provided in section 245.4871, subdivision 21, or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph (e).

(c) In the case of a child in placement due to developmental disability or a related condition, the written report shall include as an attachment, the child's individual service plan, as provided in section 256B.092, subdivision 1b; the child's individual program plan, as provided in Minnesota Rules, part 9525.0004, subpart 11; the child's waiver care plan; or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph (e).

(d) The agency must inform the child, age 12 or older, the child's parent, and the foster parent or foster care facility of the reporting and court review requirements of this section and of their right to submit information to the court:

(1) if the child or the child's parent or the foster care provider wants to send information to the court, the agency shall advise those persons of the reporting date and the date by which the agency must receive the information they want forwarded to the court so the agency is timely able submit it with the agency's report required under this subdivision;

(2) the agency must also inform the child, age 12 or older, the child's parent, and the foster care facility that they have the right to be heard in person by the court and how to exercise that right;

(3) the agency must also inform the child, age 12 or older, the child's parent, and the foster care provider that an in-court hearing will be held if requested by the child, the parent, or the foster care provider; and

(4) if, at the time required for the report under this section, a child, age 12 or older, disagrees about the foster care facility or services provided under the out-of-home placement plan required under section 260C.212, subdivision 1, the agency shall include information regarding the child's disagreement, and to the extent possible, the basis for the child's disagreement in the report required under this section.

(e) After receiving the required report, the court has jurisdiction to make the following determinations and must do so within ten days of receiving the forwarded report, whether a hearing is requested:

(1) whether the voluntary foster care arrangement is in the child's best interests;

(2) whether the parent and agency are appropriately planning for the child; and

(3) in the case of a child age 12 or older, who disagrees with the foster care facility or services provided under the out-of-home placement plan, whether it is appropriate to appoint counsel and a guardian ad litem for the child using standards and procedures under section 260C.163.

(f) Unless requested by a parent, representative of the foster care facility, or the child, no in-court hearing is required in order for the court to make findings and issue an order as required in paragraph (e).

(g) If the court finds the voluntary foster care arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child, the court shall issue an order containing explicit, individualized findings to support its determination. The individualized findings shall be based on the agency's written report and other materials submitted to the court. The court may make this determination notwithstanding the child's disagreement, if any, reported under paragraph (d).

(h) The court shall send a copy of the order to the county attorney, the agency, parent, child, age 12 or older, and the foster parent or foster care facility.

(i) The court shall also send the parent, the child, age 12 or older, the foster parent, or representative of the foster care facility notice of the permanency review hearing required under section 260D.07, paragraph (e).

(j) If the court finds continuing the voluntary foster care arrangement is not in the child's best interests or that the agency or the parent are not appropriately planning for the child, the court shall notify the agency, the parent, the foster parent or foster care facility, the child, age 12 or older, and the county attorney of the court's determinations and the basis for the court's determinations. In this case, the court shall set the matter for hearing and appoint a guardian ad litem for the child under section 260C.163, subdivision 5.

Sec. 84. Minnesota Statutes 2024, section 260D.07, is amended to read:

260D.07 REQUIRED PERMANENCY REVIEW HEARING.

(a) When the court has found that the voluntary arrangement is in the child's best interests and that the agency and parent are appropriately planning for the child pursuant to the report submitted under section 260D.06, and the child continues in voluntary foster care as defined in section 260D.02, subdivision 10, for 13 months from the date of the voluntary foster care agreement, or has been in placement for 15 of the last 22 months, the agency must:

(1) terminate the voluntary foster care agreement and return the child home; or

(2) determine whether there are compelling reasons to continue the voluntary foster care arrangement and, if the agency determines there are compelling reasons, seek judicial approval of its determination; or

(3) file a petition for the termination of parental rights.

(b) When the agency is asking for the court's approval of its determination that there are compelling reasons to continue the child in the voluntary foster care arrangement, the agency shall file a "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment" and ask the court to proceed under this section.

(c) The "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment" shall be drafted or approved by the county attorney and be under oath. The petition shall include:

(1) the date of the voluntary placement agreement;

(2) whether the petition is due to the child's developmental disability or ~~emotional disturbance~~ mental illness;

(3) the plan for the ongoing care of the child and the parent's participation in the plan;

(4) a description of the parent's visitation and contact with the child;

(5) the date of the court finding that the foster care placement was in the best interests of the child, if required under section 260D.06, or the date the agency filed the motion under section 260D.09, paragraph (b);

(6) the agency's reasonable efforts to finalize the permanent plan for the child, including returning the child to the care of the child's family;

(7) a citation to this chapter as the basis for the petition; and

(8) evidence as specified in section 260C.712 when a child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d.

(d) An updated copy of the out-of-home placement plan required under section 260C.212, subdivision 1, shall be filed with the petition.

(e) The court shall set the date for the permanency review hearing no later than 14 months after the child has been in placement or within 30 days of the petition filing date when the child has been in placement 15 of the last 22 months. The court shall serve the petition together with a notice of hearing by United States mail on the parent, the child age 12 or older, the child's guardian ad litem, if one has been appointed, the agency, the county attorney, and counsel for any party.

(f) The court shall conduct the permanency review hearing on the petition no later than 14 months after the date of the voluntary placement agreement, within 30 days of the filing of the petition when the child has been in placement 15 of the last 22 months, or within 15 days of a motion to terminate jurisdiction and to dismiss an order for foster care under chapter 260C, as provided in section 260D.09, paragraph (b).

(g) At the permanency review hearing, the court shall:

(1) inquire of the parent if the parent has reviewed the "Petition for Permanency Review Regarding a Child in Voluntary Foster Care for Treatment," whether the petition is accurate, and whether the parent agrees to the continued voluntary foster care arrangement as being in the child's best interests;

(2) inquire of the parent if the parent is satisfied with the agency's reasonable efforts to finalize the permanent plan for the child, including whether there are services available and accessible to the parent that might allow the child to safely be with the child's family;

(3) inquire of the parent if the parent consents to the court entering an order that:

(i) approves the responsible agency's reasonable efforts to finalize the permanent plan for the child, which includes ongoing future planning for the safety, health, and best interests of the child; and

(ii) approves the responsible agency's determination that there are compelling reasons why the continued voluntary foster care arrangement is in the child's best interests; and

(4) inquire of the child's guardian ad litem and any other party whether the guardian or the party agrees that:

(i) the court should approve the responsible agency's reasonable efforts to finalize the permanent plan for the child, which includes ongoing and future planning for the safety, health, and best interests of the child; and

(ii) the court should approve of the responsible agency's determination that there are compelling reasons why the continued voluntary foster care arrangement is in the child's best interests.

(h) At a permanency review hearing under this section, the court may take the following actions based on the contents of the sworn petition and the consent of the parent:

(1) approve the agency's compelling reasons that the voluntary foster care arrangement is in the best interests of the child; and

(2) find that the agency has made reasonable efforts to finalize the permanent plan for the child.

(i) A child, age 12 or older, may object to the agency's request that the court approve its compelling reasons for the continued voluntary arrangement and may be heard on the reasons for the objection. Notwithstanding the child's objection, the court may approve the agency's compelling reasons and the voluntary arrangement.

(j) If the court does not approve the voluntary arrangement after hearing from the child or the child's guardian ad litem, the court shall dismiss the petition. In this case, either:

(1) the child must be returned to the care of the parent; or

(2) the agency must file a petition under section 260C.141, asking for appropriate relief under sections 260C.301 or 260C.503 to 260C.521.

(k) When the court approves the agency's compelling reasons for the child to continue in voluntary foster care for treatment, and finds that the agency has made reasonable efforts to finalize a permanent plan for the child, the court shall approve the continued voluntary foster care arrangement, and continue the matter under the court's jurisdiction for the purposes of reviewing the child's placement every 12 months while the child is in foster care.

(l) A finding that the court approves the continued voluntary placement means the agency has continued legal authority to place the child while a voluntary placement agreement remains in effect. The parent or the agency may terminate a voluntary agreement as provided in section 260D.10. Termination of a voluntary foster care placement of an Indian child is governed by section 260.765, subdivision 4.

Sec. 85. Minnesota Statutes 2024, section 260E.11, subdivision 3, is amended to read:

Subd. 3. **Report to medical examiner or coroner; notification to local agency and law enforcement; report ombudsman.** (a) A person mandated to report maltreatment who knows or has reason to believe a child has died as a result of maltreatment shall report that information to the appropriate medical examiner or coroner instead of the local welfare agency, police department, or county sheriff.

(b) The medical examiner or coroner shall notify the local welfare agency, police department, or county sheriff in instances in which the medical examiner or coroner believes that the child has died as a result of maltreatment. The medical examiner or coroner shall complete an investigation as soon as feasible and report the findings to the police department or county sheriff and the local welfare agency.

(c) If the child was receiving services or treatment for mental illness, developmental disability, or substance use disorder~~, or emotional disturbance~~ from an agency, facility, or program as defined in section 245.91, the medical examiner or coroner shall also notify and report findings to the ombudsman established under sections 245.91 to 245.97.

Sec. 86. Minnesota Statutes 2024, section 295.50, subdivision 9b, is amended to read:

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

(1) bed and board;

(2) nursing services and other related services;

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

(4) medical social services;

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

(6) other diagnostic or therapeutic items or services;

(7) medical or surgical services;

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

(9) emergency services.

(b) "Patient services" does not include:

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

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

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

(4) services provided under the following programs: day treatment services as defined in section 245.462, subdivision 8; assertive community treatment as described in section 256B.0622; adult rehabilitative mental health services as described in section 256B.0623; crisis response services as described in section 256B.0624; and children's therapeutic services and supports as described in section 256B.0943;

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

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

(7) hospice care services;

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

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

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

ARTICLE 9

MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 62Q.75, subdivision 3, is amended to read:

Subd. 3. **Claims filing.** (a) Unless otherwise provided by contract, by section 16A.124, subdivision 4a, or by federal law, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within six months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later.

(b) A health care provider or facility that does not make an initial submission of charges within the six-month period in paragraph (a), the 12-month period in paragraph (c), or the additional six-month period

in paragraph (d) shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer.

(c) The six-month submission requirement in paragraph (a) may be extended to 12 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis.

(d) The six-month submission requirement in paragraph (a) must be extended an additional six months if a health plan company or third-party administrator makes any adjustment or recoupment of payment. The additional six months begins on the date the health plan company or third-party administrator adjusts or recoups the payment.

(e) Any request by a health care provider or facility under paragraph (c) or (d) must reference that the submission is pursuant to this subdivision.

(f) Any request by a health care provider or facility specified in subdivision 2 for an exception to a contractually defined claims submission timeline must be reviewed and acted upon by the health plan company within the same time frame as the contractually agreed upon claims filing timeline.

(g) This subdivision also applies to all health care providers and facilities that submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation obligors for treatment of an injury compensable under chapter 65B.

Sec. 2. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to read:

Subd. 44. **Notification of federal approval; report.** (a) For any provision over which the commissioner has jurisdiction and that has an effective date contingent upon federal approval, whether the contingency is expressed in an effective date, in the text of a statutory provision, or in the text of an uncodified section of session law, the commissioner must establish and maintain a public list, according to paragraph (b), of which enacted provisions contain such contingent federal approval and when federal approval is obtained for any such provision.

(b) The commissioner must post, in a single location on the department's public website, regular status updates on all provisions of Minnesota Statutes and Laws of Minnesota enacted with an effective date contingent on federal approval. The commissioner must update the list monthly to identify:

(1) provisions of Minnesota Statutes and Laws of Minnesota the commissioner has requested federal authority to effectuate;

(2) the status of the commissioner's request for federal approval;

(3) the date of federal approval, denial, or an alternative outcome; and

(4) the effective dates for approved provisions.

EFFECTIVE DATE. This section is effective December 1, 2025.

Sec. 3. **REPEALER.**

Minnesota Rules, part 9505.0250, subparts 1, 2, and 3, are repealed.

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

Presented to the governor May 20, 2025

Signed by the governor May 23, 2025, 10:58 a.m.