State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-FOURTH SESSION

H. F. No. 4338

03/16/2026 Authored by Schomacker and Noor
The bill was read for the first time and referred to the Committee on Human Services Finance and Policy
04/22/2026 Adoption of Report: Amended and re-referred to the Committee on Ways and Means

A bill for an act

relating to state government; modifying provisions relating to human services health care, the Department of Human Services Office of Inspector General, background studies, behavioral health services, uniform service standards, aging and disability services, and assisted living facilities; establishing medical assistance fraud as a crime; providing for criminal penalties; establishing working groups; making technical corrections; requiring reports; appropriating money; amending Minnesota Statutes 2024, sections 8.16, subdivision 1; 13A.03, by adding a subdivision; 142B.01, subdivision 8; 144G.41, subdivision 1, by adding a subdivision; 245.095, subdivisions 2, 5, by adding a subdivision; 245.735, subdivision 6; 245A.02, subdivision 5a; 245A.07, subdivision 2a; 245A.10, by adding a subdivision; 245A.65, subdivision 1a; 245C.02, subdivision 18; 245C.03, subdivisions 1, 3a, 9, by adding subdivisions; 245C.04, subdivision 1; 245C.15, subdivisions 2, 3, 4; 245C.24, subdivision 2; 245D.04, subdivision 3; 245D.081, subdivision 3; 245D.10, subdivision 4; 245D.12; 245G.03, subdivision 1; 245I.011, subdivisions 3, 5, by adding a subdivision; 245I.02, subdivisions 33, 39, by adding subdivisions; 245I.03, subdivision 4, by adding a subdivision; 245I.06, subdivisions 1, 2; 245I.07; 245I.10, subdivisions 6, 8, by adding a subdivision; 256B.02, by adding a subdivision; 256B.04, subdivisions 5, 10, by adding a subdivision; 256B.0623, subdivisions 1, 3, 12, by adding a subdivision; 256B.0624, subdivisions 1, 4, by adding a subdivision; 256B.0625, subdivision 17b, by adding a subdivision; 256B.064, subdivisions 1b, 1c, 1d, 2, 3, 4, 5, by adding subdivisions; 256B.0651, subdivision 17; 256B.073, subdivisions 1, 2, 3, 5, by adding subdivisions; 256B.0761, subdivision 2; 256B.0911, subdivision 32; 256B.0943, subdivision 2; 256B.0949, subdivision 17, by adding a subdivision; 256B.27, subdivision 3; 256B.4905, subdivisions 11, 12; 256B.4912, by adding a subdivision; 256B.4914, subdivision 6d, by adding a subdivision; 256B.492, by adding a subdivision; 256B.69, subdivision 5a, by adding a subdivision; 256B.85, subdivision 23a; 256S.20, by adding a subdivision; 256S.21, by adding a subdivision; 295.50, subdivision 4; 609.52, subdivision 2; Minnesota Statutes 2025 Supplement, sections 15.013, by adding a subdivision; 15.471, subdivision 6; 245A.03, subdivision 2; 245A.04, subdivisions 1, 7; 245A.05; 245A.07, subdivision 3; 245A.10, subdivisions 3, 4; 245A.142, subdivision 3; 245A.242, subdivision 2; 245C.02, subdivision 15a; 245C.05, subdivision 5; 245C.07; 245C.13, subdivision 2; 245C.15, subdivision 4a; 245C.16, subdivision 1; 245C.22, subdivision 5; 245I.04, subdivisions 5, 17; 254B.0503, subdivision 1; 256B.04, subdivision 21; 256B.051, subdivision 6; 256B.0625, subdivisions 5m, 17; 256B.0659, subdivision 21; 256B.0701, subdivision 9; 256B.0759, subdivision 4; 256B.0911, subdivision 14;

256B.0943, subdivisions 3, 12; 256B.0949, subdivision 16; 256B.12; 256B.85, subdivisions 12, 17a; 260E.03, subdivision 6; 260E.11, subdivision 1; 260E.14, subdivision 1; 295.50, subdivision 9b; 609.902, subdivision 4; 626.5572, subdivision 13; 628.26; Laws 2025, First Special Session chapter 9, article 4, sections 2; 23; 38; 39; 40; 41; 42; 43; 44; 50; 51; proposing coding for new law in Minnesota Statutes, chapters 245A; 245I; 256B; 609; repealing Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, 8; 245C.03, subdivision 7; 245I.20, subdivision 9; 245I.23, subdivision 23; 256B.055, subdivision 14; 256B.0623, subdivisions 2, 4, 5, 6, 9; 256B.0624, subdivisions 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9, 11; 256B.073, subdivision 4; 256B.0943, subdivisions 4, 5, 5a, 6, 7, 11; 609.466; Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3, 4d; 245A.10, subdivision 3a; 256B.0701, subdivision 11; 256B.0943, subdivisions 1, 9; Minnesota Rules, part 9505.2165, subpart 4.

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

ARTICLE 1

HEALTH CARE

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

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

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

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

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

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

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

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

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

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

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

(b) Controlling individual does not include:

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

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

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

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

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

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

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

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

Sec. 3. Minnesota Statutes 2024, section 245.095, is amended by adding a subdivision to read:

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

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

Sec. 4. Minnesota Statutes 2024, section 245A.02, subdivision 5a, is amended to read:

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

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

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

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

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

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

(b) Controlling individual does not include:

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

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

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

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

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

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

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

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

Sec. 5. Minnesota Statutes 2025 Supplement, 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. If the applicant or a controlling individual is the subject of a pending administrative, civil, or criminal investigation, the application is not complete until the investigation has closed or the related legal proceedings are complete.

When the commissioner receives an application for initial licensure that is incomplete because the applicant failed to submit required documents or that is substantially deficient

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

(j) An applicant or license holder who acknowledges under paragraph (i) that the applicant or license holder elects to receive any publicly funded reimbursement from the commissioner

for services provided under the license that are designated by the commissioner as high-risk under section 256B.044, subdivision 1, must provide an attestation with the notarized signature of the applicant or authorized agent stating whether the applicant or authorized agent received from an unaffiliated business or consultant any assistance preparing:

(1) the licensure application;

(2) the renewal application;

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

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

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

Sec. 6. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 7, is amended to read:

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

(1) the name of the license holder;

(2) the address of the program;

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

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

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

(6) any special conditions of licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 7. Minnesota Statutes 2025 Supplement, section 245A.05, is amended to read:

245A.05 DENIAL OF APPLICATION.

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

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

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

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

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

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

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

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

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

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

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

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

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice

must be given by certified mail, by personal service, or through the provider licensing and reporting hub. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. If the order is issued through the provider hub, the appeal must be received by the commissioner within 20 calendar days from the date the commissioner issued the order through the hub. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

Sec. 8. Minnesota Statutes 2024, section 245D.081, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 9. Minnesota Statutes 2024, section 256B.04, subdivision 5, is amended to read:

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

Sec. 10. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended to read:

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

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

~~the provider that includes a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).~~

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

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

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

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

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

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

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

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

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

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

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

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

~~(g) An enrolled provider that is also licensed by the commissioner under chapter 245A, is licensed as a home care provider by the Department of Health under chapter 144A, or is licensed as an assisted living facility under chapter 144G and has a home and~~

~~community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's~~

~~Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064.~~

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

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

Sec. 11. Minnesota Statutes 2024, section 256B.04, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

(1) is in plain language;

(2) is culturally and linguistically appropriate; and

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

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

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

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

Sec. 12. **[256B.044] PROVIDER ENROLLMENT.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) unannounced site visits, as follows:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 13. **[256B.0441] PROVIDER REVALIDATION.**

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

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

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

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

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

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

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

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

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

(2) if a provider fails to submit all required materials or satisfy the requirements of paragraph (b) by the due date, notify the provider of the deficiency within 14 days after the

due date and allow the provider an additional 14 days from the notification date to comply; and

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

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

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

Sec. 14. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND TERMINATIONS.**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(3) serves primarily a pediatric population.

Sec. 15. **[256B.0443] PROVIDER PAYMENT WITHHOLDS.**

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

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

Sec. 16. **[256B.0444] ENROLLMENT MORATORIUM FOR HIGH-RISK PROVIDERS.**

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

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

Subd. 2. **Moratorium exceptions.** The commissioner may grant exceptions to a moratorium issued under subdivision 1 and must make publicly available the processes and criteria the commissioner will use to grant exceptions. The commissioner may grant an

exception if a county or Tribal agency submits a request for an exception to the commissioner and the commissioner determines that the agency's request sufficiently shows that enrollment of the new provider:

(1) is essential to meet regional needs;

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

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

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

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

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

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

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

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

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

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

Sec. 17. **[256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS FOR SPECIFIC PROVIDER TYPES.**

Subdivision 1. **Durable medical equipment provider or supplier.** (a) For the purposes of this subdivision, "durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rent to the general

public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rent.

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

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

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

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

Sec. 18. **[256B.0446] ADDITIONAL PROVIDER ENROLLMENT TRAINING REQUIREMENTS FOR HIGH-RISK PROVIDERS.**

Subdivision 1. **Applicability.** This section applies to any agency that provides a service designated by the commissioner as high-risk under section 256B.044, subdivision 1. For

purposes of this section, "agency" means the legal entity that is applying to be or is enrolled with Minnesota health care programs as a medical assistance provider according to Minnesota Rules, part 9505.0195.

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

(b) New owners active in day-to-day management and operations of the agency and new managerial and supervisory employees of the agency must complete compliance training under this subdivision within 30 calendar days of becoming an owner of or beginning employment with the agency and prior to conducting any management or operations activities for the agency. If an individual moves to another agency providing the same service and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision. If the individual does not repeat the compliance training, the individual must provide documentation to the agency that proves that the individual completed the compliance training within the provider revalidation schedule for the relevant provider type as determined by the commissioner under section 256B.0441, subdivisions 2 and 3.

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

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

(2) enrollment requirements;

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

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

Sec. 19. **[256B.0447] ENHANCED PREPAYMENT REVIEW.**

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

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

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

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

(3) a new provider enrolls in medical assistance.

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

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

Subd. 3. **Review requirements.** (a) The commissioner must implement an enhanced prepayment review established under subdivision 2, paragraph (a), within 15 days after the date of the high-risk designation, effective for a period of up to 24 months from the date the review is implemented.

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

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

(1) the basis for the review;

(2) the effective date of the review; and

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

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

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

(1) the basis for the review;

(2) the effective date of the review;

(3) the providers, provider types, covered services, or categories of claims to which enhanced prepayment review applies;

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

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

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

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

Subd. 7. **Duration and termination.** (a) Enhanced prepayment review may continue for up to 24 consecutive months unless:

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

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

(b) Claims for services furnished during the period of enhanced prepayment review remain subject to review before payment regardless of when the claims are submitted.

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

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

(1) the providers, provider types, covered services, or categories of claims subject to review;

(2) the duration of the review;

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

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

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

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

Sec. 20. **[256B.0448] POSTPAYMENT REVIEW.**

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

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

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

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

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

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

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

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

Sec. 21. **[256B.045] RECIPIENT PROTECTIONS AND CONTINUITY OF CARE WHEN A PROVIDER IS SUBJECT TO A SERIOUS OPERATIONAL EVENT.**

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) When a medical assistance service provider provides notice to the commissioner under subdivision 2 that it is unable to continue to provide services to a recipient due to a serious operational event, the commissioner must assist the provider and the lead agency in supporting the recipient in transitioning to another provider of the recipient's choice.

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

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

(1) is continuing to receive needed services; and

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

Sec. 22. **[256B.046] COMPLEX TRANSITIONS.**

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

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

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

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

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

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

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

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

(1) recipient identification and acuity level;

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

(3) medical record, medication, and treatment plan continuity procedures;

(4) receiving provider identification and capacity information;

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

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

(7) coordination with lead agencies, case managers, and ombudsperson offices, when applicable.

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

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

Sec. 23. **[256B.047] CONTINUITY PERIOD AND TRANSITION PAYMENTS FOR COMPLEX TRANSITIONS.**

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

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

Subd. 3. **Transition payments.** (a) If the commissioner does not suspend payments to a provider sanctioned under section 256B.064 due to a determination of good cause, payments to the provider must be limited to direct recipient care costs. A provider receiving payments under this section must submit to independent financial monitoring and a prohibition on financial distributions to owners.

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

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

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

Sec. 24. Minnesota Statutes 2025 Supplement, section 256B.051, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

(1) suspending payments to an individual or entity;

(2) withholding payments to an individual or entity;

(3) suspending participation in the program;

(4) terminating participation in the program; or

(5) imposing a fine under subdivision 2a.

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

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

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

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

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

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

(b) The commissioner may obtain monetary recovery using methods including but not limited to the following: assessing and recovering money improperly paid and debiting from

future payments any money improperly paid. The commissioner ~~shall~~ must charge interest on money to be recovered if the recovery is to be made by installment payments or debits, except when the monetary recovery is of an overpayment that resulted from a department error. The interest charged ~~shall~~ must be the rate established by the commissioner of revenue under section 270C.40.

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

Sec. 27. Minnesota Statutes 2024, section 256B.064, subdivision 1d, is amended to read:

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

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

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

Sec. 28. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

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

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

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

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

~~(i) fraud hotline complaints;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) other information required by the commissioner.

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

~~severity, and chronicity of the violations, in an amount of up to $5,000 or 20 percent of the value of the claims, whichever is greater.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) fraud hotline complaints;

(ii) claims data mining;

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

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

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

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

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

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

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

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

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

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

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

Subd. 2e. **Forfeiture of withheld payments upon criminal conviction.** Upon conviction for a crime related to the provision, management, or administration of a health service under medical assistance, a payment held pursuant to this section by the commissioner or a managed

care organization that contracts with the commissioner under section 256B.035 is forfeited to the commissioner or managed care organization, regardless of the amount charged in the criminal complaint or the amount of criminal restitution ordered.

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

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

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

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

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

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

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

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

(3) other fines or penalties allowed by law.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 41. **[256B.0647] REMITTANCE ADVICE MONETARY RECOVERY.**

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

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

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

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

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

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

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

(5) other information required by the commissioner.

Sec. 42. Minnesota Statutes 2024, section 256B.0651, subdivision 17, is amended to read:

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

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

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

Sec. 43. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 44. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is amended to read:

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

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

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

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

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

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

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

Sec. 45. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 46. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

Subd. 17. **Provider shortage; authority for exceptions.** (a) In consultation with the Early Intensive Developmental and Behavioral Intervention Advisory Council and stakeholders, including agencies, professionals, parents of people with ASD or a related condition, and advocacy organizations, the commissioner shall determine if a shortage of EIDBI providers exists. For the purposes of this subdivision, "shortage of EIDBI providers" means a lack of availability of providers who meet the EIDBI provider qualification requirements under subdivision 15 that results in the delay of access to timely services under this section, or that significantly impairs the ability of a provider agency to have sufficient

providers to meet the requirements of this section. The commissioner shall consider geographic factors when determining the prevalence of a shortage. The commissioner may determine that a shortage exists only in a specific region of the state, multiple regions of the state, or statewide. The commissioner shall also consider the availability of various types of treatment modalities covered under this section.

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

(1) EIDBI provider qualifications under this section;

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

(3) EIDBI provider or agency standards or requirements.

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

Sec. 47. Minnesota Statutes 2024, section 256B.69, subdivision 5a, is amended to read:

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

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B

and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

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

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

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

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

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

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

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

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

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

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

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

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

(j) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the

form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

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

Sec. 48. Minnesota Statutes 2024, section 256B.69, is amended by adding a subdivision to read:

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

Sec. 49. Minnesota Statutes 2024, section 256B.85, subdivision 23a, is amended to read:

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

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

(c) Agency-providers of CFSS services or FMS providers must ~~provide each participant with a copy of participant protections in subdivision 20c at least 30 days prior to terminating services to a participant, if the termination results from sanctions under this subdivision or section 256B.064, such as a payment withhold or a suspension or termination of the provider~~

~~enrollment number. If a CFSS agency-provider, FMS provider, or consultation services provider determines it is unable to continue providing services to a participant because of an action under this subdivision or section 256B.064, the agency-provider, FMS provider, or consultation services provider must notify the participant, the participant's representative, and the commissioner 30 days prior to terminating services to the participant, and must assist the commissioner and lead agency in supporting the participant in transitioning to another CFSS agency-provider, FMS provider, or consultation services provider of the participant's choice~~ meet the recipient protection requirements under section 256B.045 when subject to a serious operational event as defined in section 256B.045, subdivision 1.

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

Sec. 50. **MANDATORY COMPLIANCE TRAINING FOR CURRENTLY ENROLLED HIGH-RISK MEDICAL ASSISTANCE PROVIDERS.**

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

Sec. 51. **REPEALER.**

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

ARTICLE 2

DEPARTMENT OF HUMAN SERVICES OFFICE OF INSPECTOR GENERAL POLICY

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

Subd. 2a. **Exception.** Law enforcement may delay notification under section 13A.02, subdivision 3, or authorize another government authority to delay notification to a customer without a court order if law enforcement determines in writing that notification would compromise the integrity of a current and ongoing criminal investigation. The written determination from law enforcement must be renewed every 90 days.

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

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

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

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

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

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

(1) fraud hotline complaints;

(2) claims data mining;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

~~(1) fraud hotline complaints;~~

~~(2) claims data mining;~~

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

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

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

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

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

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

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

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

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

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

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

Sec. 4. Minnesota Statutes 2024, section 245A.07, subdivision 2a, is amended to read:

Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a notice of hearing by certified mail or personal service at least ten working days before the hearing. The scope of the hearing shall be limited solely to the issue of whether the temporary immediate suspension should remain in effect pending the commissioner's final order under section 245A.08, regarding a licensing sanction issued under subdivision 3 following the immediate suspension. For suspensions under subdivision 2, paragraph (a), clause (1), the burden of proof in expedited hearings under this subdivision ~~shall be limited to~~ is met only if the ~~commissioner's demonstration~~ commissioner demonstrates that reasonable cause exists to believe that the license holder's or controlling individual's actions or failure to comply with applicable law or rule poses, or the actions of other individuals or conditions in the program poses an imminent risk of harm to the health, safety, or rights of persons served by the program. "Reasonable cause" means there exist specific articulable facts or circumstances which provide the commissioner with a reasonable suspicion that there is an imminent risk of harm to the health, safety, or rights of persons served by the program. When the commissioner has determined there is reasonable cause to order the temporary immediate suspension of a license based on a violation of safe sleep requirements, as defined in section 245A.1435, the commissioner is not required to demonstrate that an infant died or was injured as a result of the safe sleep violations. For suspensions under subdivision 2, paragraph (a), clause (2), the burden of proof in expedited hearings under this subdivision ~~shall be limited to~~ is met only if the ~~commissioner's demonstration~~ commissioner demonstrates by a preponderance of the evidence that, since the license was revoked, the license holder committed additional violations of law or rule which may adversely affect the health or safety of persons served by the program.

(b) The administrative law judge shall issue findings of fact, conclusions, and a recommendation within ten working days from the date of hearing. The parties shall have

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

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

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

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

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

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

(e) For suspensions under subdivision 2, paragraph (a), clause (3), the burden of proof in expedited hearings under this subdivision ~~shall be limited to~~ is met only if the ~~commissioner's demonstration~~ commissioner demonstrates by a preponderance of the evidence that a criminal complaint and warrant or summons was issued for the license holder

or controlling individual that was not dismissed, and that the criminal charge is an offense that involves fraud or theft against a program administered by the commissioner.

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

Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.07, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts

1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. If the order is issued through the provider hub, the appeal must be received by the commissioner within ten calendar days from the date the commissioner issued the order through the hub. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (i) and (j), until the commissioner issues a final order on the suspension or revocation.

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

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

(3) A license holder shall promptly notify the commissioner of human services, in writing, when a violation specified in the order to forfeit a fine is corrected. If upon reinspection the commissioner determines that a violation has not been corrected as indicated by the order to forfeit a fine, the commissioner may issue a second fine. The commissioner shall notify the license holder by certified mail, by personal service, or through the provider licensing

and reporting hub that a second fine has been assessed. The license holder may appeal the second fine as provided under this subdivision.

(4) Fines shall be assessed as follows:

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

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

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

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

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

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

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the

provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

Sec. 6. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$250
greater than $10,000 but less than or equal to $25,000	$375
greater than $25,000 but less than or equal to $50,000	$500
greater than $50,000 but less than or equal to $100,000	$625
greater than $100,000 but less than or equal to $150,000	$750
greater than $150,000 but less than or equal to $200,000	$1,000
greater than $200,000 but less than or equal to $250,000	$1,250
greater than $250,000 but less than or equal to $300,000	$1,500
greater than $300,000 but less than or equal to $350,000	$1,750
greater than $350,000 but less than or equal to $400,000	$2,000
greater than $400,000 but less than or equal to $450,000	$2,250
greater than $450,000 but less than or equal to $500,000	$2,500
greater than $500,000 but less than or equal to $600,000	$2,850
greater than $600,000 but less than or equal to $700,000	$3,200
greater than $700,000 but less than or equal to $800,000	$3,600

greater than $800,000 but less than or equal to $900,000	$3,900
greater than $900,000 but less than or equal to $1,000,000	$4,250
greater than $1,000,000 but less than or equal to $1,250,000	$4,550
greater than $1,250,000 but less than or equal to $1,500,000	$4,900
greater than $1,500,000 but less than or equal to $1,750,000	$5,200
greater than $1,750,000 but less than or equal to $2,000,000	$5,500
greater than $2,000,000 but less than or equal to $2,500,000	$5,900
greater than $2,500,000 but less than or equal to $3,000,000	$6,200
greater than $3,000,000 but less than or equal to $3,500,000	$6,500
greater than $3,500,000 but less than or equal to $4,000,000	$7,200
greater than $4,000,000 but less than or equal to $4,500,000	$7,800
greater than $4,500,000 but less than or equal to $5,000,000	$9,000
greater than $5,000,000 but less than or equal to $7,500,000	$10,000
greater than $7,500,000 but less than or equal to $10,000,000	$14,000
greater than $10,000,000 but less than or equal to $12,500,000	$18,000
greater than $12,500,000 but less than or equal to $15,000,000	$25,000
greater than $15,000,000 but less than or equal to $17,500,000	$28,000
greater than $17,500,000 but less than or equal to $20,000,000	$32,000
greater than $20,000,000 but less than or equal to $25,000,000	$36,000
greater than $25,000,000 but less than or equal to $30,000,000	$45,000
greater than $30,000,000 but less than or equal to $35,000,000	$55,000
greater than $35,000,000	$75,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(b) A substance use disorder treatment program licensed under chapter 245G, to provide substance use disorder treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 to 74 persons	$5,000
75 to 99 persons	$10,000
100 to 199 persons	$15,000
200 or more persons	$20,000

(c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 or more persons	$5,000

A detoxification program that also operates a withdrawal management program at the same location shall only pay one fee based upon the licensed capacity of the program with the higher overall capacity.

(d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200

75 to 99 persons	$1,300
100 or more persons	$1,400

(e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 or more persons	$20,000

(f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(g) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 to 74 persons	$5,000
75 to 99 persons	$10,000
100 to 199 persons	$15,000
200 or more persons	$20,000

(h) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

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

primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

(j) If a program subject to annual fees under paragraph (b) provides services at a primary location with satellite facilities, the satellite facilities must be licensed with the primary location and must be subject to an additional $500 annual nonrefundable license fee per satellite facility.

Sec. 7. Minnesota Statutes 2025 Supplement, section 245A.142, subdivision 3, is amended to read:

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

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

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

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

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

(f) Initial provisional license applications are subject to the $2,100 application fee under section 245A.10, subdivision 3.

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

Sec. 8. Minnesota Statutes 2025 Supplement, section 245A.242, subdivision 2, is amended to read:

Subd. 2. **Emergency overdose treatment.** (a) A license holder must maintain a supply of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency treatment of opioid overdose ~~and~~. For administration via intramuscular injection, a license

holder must have a written standing order protocol by a physician who is licensed under chapter 147, advanced practice registered nurse who is licensed under chapter 148, or physician assistant who is licensed under chapter 147A, that permits the license holder to maintain a supply of intramuscular injection opiate antagonists on site. A license holder must require staff to undergo training in the specific mode of administration used at the program, which may include intranasal administration, intramuscular injection, or both, before the staff has direct contact, as defined in section 245C.02, subdivision 11, with a person served by the program.

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

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

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

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

Sec. 9. Minnesota Statutes 2024, section 245C.02, subdivision 18, is amended to read:

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

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

(1) diagnostic testing, assessment, or observation;

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

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

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

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

Sec. 10. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Programs licensed by the commissioner.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees of the applicant or license holder who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15; and

(7) all controlling individuals as defined in section 245A.02, subdivision 5a;

(8) notwithstanding clause (3), for children's residential facilities and foster residence settings, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

(b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

(c) This subdivision applies to the following programs that must be licensed under chapter 245A:

(1) adult foster care;

(2) children's residential facilities;

(3) licensed home and community-based services under chapter 245D;

(4) residential mental health programs for adults;

(5) substance use disorder treatment programs under chapter 245G;

(6) withdrawal management programs under chapter 245F;

(7) adult day care centers;

(8) family adult day services;

(9) detoxification programs;

(10) community residential settings;

(11) intensive residential treatment services and residential crisis stabilization under chapter 245I; ~~and~~

(12) treatment programs for persons with sexual psychopathic personality or sexually dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts 9515.3000 to 9515.3110~~.~~; and

(13) children's foster residence settings.

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

Sec. 11. Minnesota Statutes 2024, section 245C.04, subdivision 1, is amended to read:

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

(b) The commissioner shall conduct a background study of an individual required to be studied under section 245C.03, subdivision 1, including a child care background study subject as defined in section 245C.02, subdivision 6a, in a family child care program, licensed child care center, certified license-exempt child care center, or legal nonlicensed child care provider, on a schedule determined by the commissioner. Except as provided in section 245C.05, subdivision 5a, a child care background study must include submission of fingerprints for a national criminal history record check and a review of the information under section 245C.08. A background study for a child care program must be repeated within five years from the most recent study conducted under this paragraph.

(c) At reauthorization or when a new background study is needed under section 142E.16, subdivision 2, for a legal nonlicensed child care provider authorized under chapter 142E:

(1) for a background study affiliated with a legal nonlicensed child care provider, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the commissioner and be fingerprinted and photographed under section 245C.05, subdivision 5; and

(2) the commissioner shall verify the information received under clause (1) and submit the request in NETStudy 2.0 to complete the background study.

(d) At reapplication for a family child care license:

(1) for a background study affiliated with a licensed family child care center, the individual shall provide information required under section 245C.05, subdivision 1, paragraphs (a), (b), and (d), to the county agency, and be fingerprinted and photographed under section 245C.05, subdivision 5;

(2) the county agency shall verify the information received under clause (1) and forward the information to the commissioner and submit the request in NETStudy 2.0 to complete the background study; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08.

~~(e) The commissioner is not required to conduct a study of an individual at the time of reapplication for a license if the individual's background study was completed by the commissioner of human services and the following conditions are met:~~

~~(1) a study of the individual was conducted either at the time of initial licensure or when the individual became affiliated with the license holder;~~

~~(2) the individual has been continuously affiliated with the license holder since the last study was conducted; and~~

~~(3) the last study of the individual was conducted on or after October 1, 1995.~~

~~(f)~~ (e) The commissioner of human services shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated, or currently affiliated without a background study that was submitted through the electronic system known as NETStudy 2.0, with a child foster family setting license holder:

(1) the county or private agency shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1 and 5, when the child foster family setting applicant or license holder resides in the home where child foster care services are provided; and

(2) the background study conducted by the commissioner of human services under this paragraph must include a review of the information required under section 245C.08, subdivisions 1, 3, and 4.

~~(g)~~ (f) The commissioner shall conduct a background study of an individual specified under section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), who is newly affiliated, or currently affiliated without a background study that was submitted through the electronic system known as NETStudy 2.0, with an adult foster care or family adult day services and with a family child care license holder or a legal nonlicensed child care provider authorized under chapter 142E and:

(1) except as provided in section 245C.05, subdivision 5a, the county shall collect and forward to the commissioner the information required under section 245C.05, subdivision 1, paragraphs (a) and (b), and subdivision 5, paragraph (b), for background studies conducted by the commissioner for all family adult day services, for adult foster care when the adult foster care license holder resides in the adult foster care residence, and for family child care and legal nonlicensed child care authorized under chapter 142E;

(2) the license holder shall collect and forward to the commissioner the information required under section 245C.05, subdivisions 1, paragraphs (a) and (b); and 5, paragraphs (a) and (b), for background studies conducted by the commissioner for adult foster care when the license holder does not reside in the adult foster care residence; and

(3) the background study conducted by the commissioner under this paragraph must include a review of the information required under section 245C.08, subdivision 1, paragraph (a), and subdivisions 3 and 4.

~~(h)~~ (g) Applicants for licensure, license holders, and other entities as provided in this chapter must submit completed background study requests to the commissioner using the electronic system known as NETStudy 2.0 before individuals specified in section 245C.03, subdivision 1, begin positions allowing direct contact in any licensed program.

~~(i)~~ (h) For an individual who is not on the entity's active roster, the entity must initiate a new background study through NETStudy when:

(1) an individual returns to a position requiring a background study following an absence of 120 or more consecutive days; or

(2) a program that discontinued providing licensed direct contact services for 120 or more consecutive days begins to provide direct contact licensed services again.

The license holder shall maintain a copy of the notification provided to the commissioner under this paragraph in the program's files. If the individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

~~(j)~~ (i) For purposes of this section, a physician licensed under chapter 147, advanced practice registered nurse licensed under chapter 148, or physician assistant licensed under chapter 147A is considered to be continuously affiliated upon the license holder's receipt from the commissioner of health or human services of the physician's, advanced practice registered nurse's, or physician assistant's background study results.

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

~~(l)~~ (k) A repeat background study at the time of license renewal is not required if the family child care substitute caregiver's background study was completed by the commissioner on or after October 1, 2017, and the substitute caregiver is on the license holder's active roster in NETStudy 2.0.

~~(m)~~ (l) Before and after school programs authorized under chapter 142E, are exempt from the background study requirements under section 123B.03, for an employee for whom a background study under this chapter has been completed.

Sec. 12. Minnesota Statutes 2025 Supplement, section 245C.07, is amended to read:

245C.07 STUDY SUBJECT AFFILIATED WITH MULTIPLE FACILITIES.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice

that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study. When more time is necessary to complete a background study of an individual affiliated with a Title IV-E eligible children's residential facility or foster residence setting, the individual may not work in the facility or setting regardless of whether or not the individual is supervised;

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

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

(b) For a child care background study ~~affiliated with a licensed child care center or certified license-exempt child care center~~ subject required to submit fingerprints for a national criminal history check, except as provided in section 245C.05, subdivision 5a, the notice sent under paragraph (a), clause (1), item (ii), must not be issued until the commissioner receives a qualifying result for the individual for the fingerprint-based national criminal history record check or the fingerprint-based criminal history information from the Bureau of Criminal Apprehension. The notice must require the individual to be under continuous direct supervision prior to completion of the remainder of the background study except as permitted in subdivision 3.

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

(1) being issued a license;

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

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

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

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

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

(7) for background studies affiliated with a personal care provider organization, except as provided in section 245C.03, subdivision 3b, before a personal care assistant provides services, the personal care assistance provider agency must initiate a background study of the personal care assistant under this chapter and the personal care assistance provider agency must have received a notice from the commissioner that the personal care assistant is:

(i) not disqualified under section 245C.14; or

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22; or

(8) for background studies affiliated with an early intensive developmental and behavioral intervention provider, before an individual provides services, the early intensive developmental and behavioral intervention provider must initiate a background study for the individual under this chapter and the early intensive developmental and behavioral intervention provider must have received a notice from the commissioner that the individual is:

(i) not disqualified under section 245C.14; or

(ii) disqualified, but the individual has received a set-aside of the disqualification under section 245C.22.

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

Sec. 14. Minnesota Statutes 2024, section 245C.15, subdivision 2, is amended to read:

Subd. 2. **15-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than 15 years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a felony-level violation of any of the following offenses: sections 152.021, subdivision 1 or 2b, (aggravated controlled substance crime in the first degree; sale crimes); 152.022, subdivision 1 (controlled substance crime in the second degree; sale crimes); 152.023, subdivision 1 (controlled substance crime in the third degree; sale crimes); 152.024, subdivision 1 (controlled substance crime in the fourth degree; sale crimes); 256.98 (wrongfully obtaining assistance); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 518B.01, subdivision 14 (violation of an order for protection); 609.165 (felon ineligible to possess firearm); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.215 (suicide); 609.223

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

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

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

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

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

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

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

Subd. 3. **Ten-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than ten years have passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a gross misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 260B.425 (criminal jurisdiction for contributing to status as a juvenile petty offender or delinquency); 260C.425 (criminal jurisdiction for contributing to need for protection or services); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113, or 609.2114 (criminal vehicular homicide or injury); 609.221 or 609.222 (assault in the first or second degree); 609.223 or 609.2231 (assault in the third or fourth degree); 609.224 (assault in the fifth degree); 609.224, subdivision 2, paragraph (c) (assault in the fifth degree by a caregiver against a vulnerable adult); 609.2242 and 609.2243 (domestic assault); 609.23 (mistreatment of persons confined); 609.231 (mistreatment of residents or patients); 609.2325 (criminal abuse of a vulnerable adult); 609.233 (criminal neglect of a vulnerable adult); 609.2334 (violation of an order for protection against financial exploitation of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.265 (abduction); 609.275 (attempt to coerce); 609.324, subdivision 1a (other prohibited acts; minor engaged in prostitution); 609.33 (disorderly house); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.466 (medical assistance fraud); 609.52 (theft); 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.582 (burglary); 609.59 (possession of burglary tools); 609.611 (insurance fraud); 609.631

(check forgery; offering a forged check); 609.66 (dangerous weapons); 609.71 (riot); 609.72, subdivision 3 (disorderly conduct against a vulnerable adult); 609.746 (interference with privacy); 609.749, subdivision 2 (harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.241 (obscene materials and performances); 617.243 (indecent literature, distribution); 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01, subdivision 14.

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

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

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

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

Sec. 16. Minnesota Statutes 2024, section 245C.15, subdivision 4, is amended to read:

Subd. 4. **Seven-year disqualification.** (a) An individual is disqualified under section 245C.14 if: (1) less than seven years has passed since the discharge of the sentence imposed, if any, for the offense; and (2) the individual has committed a misdemeanor-level violation of any of the following offenses: sections 256.98 (wrongfully obtaining assistance); 260B.425 (criminal jurisdiction for contributing to status as a juvenile petty offender or delinquency); 260C.425 (criminal jurisdiction for contributing to need for protection or services); 268.182 (fraud); 393.07, subdivision 10, paragraph (c) (federal SNAP fraud); 609.2112, 609.2113,

or 609.2114 (criminal vehicular homicide or injury); 609.221 (assault in the first degree); 609.222 (assault in the second degree); 609.223 (assault in the third degree); 609.2231 (assault in the fourth degree); 609.224 (assault in the fifth degree); 609.2242 (domestic assault); 609.2334 (violation of an order for protection against financial exploitation of a vulnerable adult); 609.2335 (financial exploitation of a vulnerable adult); 609.234 (failure to report maltreatment of a vulnerable adult); 609.2672 (assault of an unborn child in the third degree); 609.27 (coercion); violation of an order for protection under 609.3232 (protective order authorized; procedures; penalties); 609.466 (medical assistance fraud); 609.52 (theft); 609.522 (organized retail theft); 609.525 (bringing stolen goods into Minnesota); 609.527 (identity theft); 609.53 (receiving stolen property); 609.535 (issuance of dishonored checks); 609.611 (insurance fraud); 609.66 (dangerous weapons); 609.665 (spring guns); 609.746 (interference with privacy); 609.79 (obscene or harassing telephone calls); 609.795 (letter, telegram, or package; opening; harassment); 609.82 (fraud in obtaining credit); 609.821 (financial transaction card fraud); 617.23 (indecent exposure), not involving a minor; 617.293 (harmful materials; dissemination and display to minors prohibited); or Minnesota Statutes 2012, section 609.21; or violation of an order for protection under section 518B.01 (Domestic Abuse Act).

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

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

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

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

(d) An individual is disqualified under section 245C.14 if less than seven years has passed since the discharge of the sentence imposed for an offense in any other state or

country, the elements of which are substantially similar to the elements of any of the offenses listed in paragraphs (a) and (b).

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

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

Sec. 17. Minnesota Statutes 2025 Supplement, section 245C.15, subdivision 4a, is amended to read:

Subd. 4a. **Licensed family foster setting disqualifications.** (a) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated with a licensed family foster setting, regardless of how much time has passed, an individual is disqualified under section 245C.14 if the individual committed an act that resulted in a felony-level conviction for sections: 609.185 (murder in the first degree); 609.19 (murder in the second degree); 609.195 (murder in the third degree); 609.20 (manslaughter in the first degree); 609.205 (manslaughter in the second degree); 609.2112 (criminal vehicular homicide); 609.221 (assault in the first degree); 609.223, subdivision 2 (assault in the third degree, past pattern of child abuse); 609.223, subdivision 3 (assault in the third degree, victim under four); a felony offense under sections 609.2242 and 609.2243 (domestic assault, spousal abuse, child abuse or neglect, or a crime against children); 609.2247 (domestic assault by strangulation); 609.2325 (criminal abuse of a vulnerable adult resulting in the death of a vulnerable adult); 609.245 (aggravated robbery); 609.247, subdivision 2 or 3 (carjacking in the first or second degree); 609.25 (kidnapping); 609.255 (false imprisonment); 609.2661 (murder of an unborn child in the first degree); 609.2662 (murder of an unborn child in the second degree); 609.2663 (murder of an unborn child in the third degree); 609.2664 (manslaughter of an unborn child in the first degree); 609.2665 (manslaughter of an unborn child in the second degree); 609.267 (assault of an unborn child in the first degree); 609.2671 (assault of an unborn child in the second degree); 609.268 (injury or death of an unborn child in the commission of a crime); 609.322, subdivision 1 (solicitation, inducement, and

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

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

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

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

(3) committed an act against or involving a minor that resulted in a felony-level conviction for: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224 (assault in the fifth degree); or

(4) committed an act that resulted in a misdemeanor or gross misdemeanor-level conviction for section 617.293 (dissemination and display of harmful materials to minors).

(c) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if fewer than 20 years have passed since the termination of the individual's parental rights under section 260C.301, subdivision 1, paragraph (b), or if the individual consented to a termination of parental rights under section 260C.301, subdivision 1, paragraph (a), to settle a petition to involuntarily terminate parental rights. An individual is disqualified under section 245C.14 if fewer than 20 years have passed since the termination of the individual's parental rights in any other state or country, where the conditions for the individual's termination of parental rights are substantially similar to the conditions in section 260C.301, subdivision 1, paragraph (b).

(d) Notwithstanding subdivisions 1 to 4, 4b, and 4c, for a background study affiliated with a licensed family foster setting, an individual is disqualified under section 245C.14 if fewer than five years have passed since a felony-level violation for sections: 152.021 (controlled substance crime in the first degree); 152.022 (controlled substance crime in the second degree); 152.023 (controlled substance crime in the third degree); 152.024 (controlled substance crime in the fourth degree); 152.025 (controlled substance crime in the fifth degree); 152.0261 (importing controlled substances across state borders); 152.0262, subdivision 1, paragraph (b) (possession of substance with intent to manufacture methamphetamine); 152.027, subdivision 6, paragraph (c) (sale or possession of synthetic cannabinoids); 152.096 (conspiracies prohibited); 152.097 (simulated controlled substances); 152.136 (anhydrous ammonia; prohibited conduct; criminal penalties; civil liabilities); 152.137 (fentanyl- and methamphetamine-related crimes involving children or vulnerable adults); 169A.24 (felony first-degree driving while impaired); 243.166 (violation of predatory offender registration requirements); 609.2113 (criminal vehicular operation; bodily harm); 609.2114 (criminal vehicular operation; unborn child); 609.228 (great bodily harm caused by distribution of drugs); 609.2325 (criminal abuse of a vulnerable adult not resulting in the death of a vulnerable adult); 609.233 (criminal neglect); 609.235 (use of drugs to injure or facilitate a crime); 609.24 (simple robbery); 609.247, subdivision 4 (carjacking in the third degree); 609.322, subdivision 1a (solicitation, inducement, and promotion of prostitution; sex trafficking in the second degree); 609.498, subdivision 1 (tampering with a witness in the first degree); 609.498, subdivision 1b (aggravated first-degree witness tampering); 609.562 (arson in the second degree); 609.563 (arson in the third degree); 609.582, subdivision 2 (burglary in the second degree); 609.66 (felony dangerous weapons); 609.687 (adulteration); 609.713 (terroristic threats); 609.749, subdivision 3, 4, or 5 (felony-level harassment or stalking); 609.855, subdivision 5 (shooting at or in a public transit vehicle or facility); or 624.713 (certain people not to possess firearms).

(e) Notwithstanding subdivisions 1 to 4, 4b, and 4c, except as provided in paragraph (a), for a background study affiliated with a licensed family child foster care license, an individual is disqualified under section 245C.14 if fewer than five years have passed since:

(1) a felony-level violation for an act not against or involving a minor that constitutes: section 609.222 (assault in the second degree); 609.223, subdivision 1 (assault in the third degree); 609.2231 (assault in the fourth degree); or 609.224, subdivision 4 (assault in the fifth degree);

(2) a violation of an order for protection under section 518B.01, subdivision 14;

(3) a determination or disposition of the individual's failure to make required reports under section 260E.06 or 626.557, subdivision 3, for incidents in which the final disposition under chapter 260E or section 626.557 was substantiated maltreatment and the maltreatment was recurring or serious;

(4) a determination or disposition of the individual's substantiated serious or recurring maltreatment of a minor under chapter 260E, a vulnerable adult under section 626.557, or serious or recurring maltreatment in any other state, the elements of which are substantially similar to the elements of maltreatment under chapter 260E or section 626.557 and meet the definition of serious maltreatment or recurring maltreatment;

(5) a gross misdemeanor-level violation for sections: 609.224, subdivision 2 (assault in the fifth degree); 609.2242 and 609.2243 (domestic assault); 609.233 (criminal neglect); 609.377 (malicious punishment of a child); 609.378 (neglect or endangerment of a child); 609.746 (interference with privacy); 609.749 (stalking); or 617.23 (indecent exposure); or

(6) committing an act against or involving a minor that resulted in a misdemeanor-level violation of section 609.224, subdivision 1 (assault in the fifth degree).

(f) For purposes of this subdivision, the disqualification begins from:

(1) the date of the alleged violation, if the individual was not convicted;

(2) the date of conviction, if the individual was convicted of the violation but not committed to the custody of the commissioner of corrections; or

(3) the date of release from prison, if the individual was convicted of the violation and committed to the custody of the commissioner of corrections.

Notwithstanding clause (3), if the individual is subsequently reincarcerated for a violation of the individual's supervised release, the disqualification begins from the date of release from the subsequent incarceration.

(g) An individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (a) and (b), as each of these offenses is defined in Minnesota Statutes, permanently disqualifies the individual under section 245C.14. An individual is disqualified under section 245C.14 if fewer than five years have passed since the individual's aiding and abetting, attempt, or conspiracy to commit any of the offenses listed in paragraphs (d) and (e).

(h) An individual's offense in any other state or country, where the elements of the offense are substantially similar to any of the offenses listed in paragraphs (a) and (b), permanently disqualifies the individual under section 245C.14. An individual is disqualified

under section 245C.14 if fewer than five years have passed since an offense in any other state or country, the elements of which are substantially similar to the elements of any offense listed in paragraphs (d) and (e).

Sec. 18. Minnesota Statutes 2025 Supplement, section 245C.22, subdivision 5, is amended to read:

Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under this section, the disqualified individual remains disqualified, but may hold a license and have direct contact with or access to persons receiving services. Except as provided in paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the licensed program, applicant, or agency specified in the set aside notice under section 245C.23. For personal care provider organizations, financial management services organizations, community first services and supports organizations, unlicensed home and community-based organizations, and consumer-directed community supports organizations, the commissioner's set-aside may further be limited to a specific individual who is receiving services. For new background studies required under section 245C.04, subdivision 1, paragraph ~~(h)~~ (g), if an individual's disqualification was previously set aside for the license holder's program and the new background study results in no new information that indicates the individual may pose a risk of harm to persons receiving services from the license holder, the previous set-aside shall remain in effect.

(b) If the commissioner has previously set aside an individual's disqualification for one or more programs or agencies, and the individual is the subject of a subsequent background study for a different program or agency, the commissioner shall determine whether the disqualification is set aside for the program or agency that initiated the subsequent background study. A notice of a set-aside under paragraph (c) shall be issued within 15 working days if all of the following criteria are met:

(1) the subsequent background study was initiated in connection with a program licensed or regulated under the same provisions of law and rule for at least one program for which the individual's disqualification was previously set aside by the commissioner;

(2) the individual is not disqualified for an offense specified in section 245C.15, subdivision 1 or 2;

(3) the commissioner has received no new information to indicate that the individual may pose a risk of harm to any person served by the program; and

(4) the previous set-aside was not limited to a specific person receiving services.

(c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the substance use disorder field, if the commissioner has previously set aside an individual's disqualification for one or more programs or agencies in the substance use disorder treatment field, and the individual is the subject of a subsequent background study for a different program or agency in the substance use disorder treatment field, the commissioner shall set aside the disqualification for the program or agency in the substance use disorder treatment field that initiated the subsequent background study when the criteria under paragraph (b), clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified in section 245C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued within 15 working days.

(d) When a disqualification is set aside under paragraph (b), the notice of background study results issued under section 245C.17, in addition to the requirements under section 245C.17, shall state that the disqualification is set aside for the program or agency that initiated the subsequent background study. The notice must inform the individual that the individual may request reconsideration of the disqualification under section 245C.21 on the basis that the information used to disqualify the individual is incorrect.

Sec. 19. Minnesota Statutes 2024, section 245C.24, subdivision 2, is amended to read:

Subd. 2. **Permanent bar to set aside a disqualification.** (a) Except as provided in paragraphs (b) to ~~(g)~~ (f), the commissioner may not set aside the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 1.

(b) For an individual in the substance use disorder or corrections field who was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and whose disqualification was set aside prior to July 1, 2005, the commissioner must consider granting a variance pursuant to section 245C.30 for the license holder for a program dealing primarily with adults. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the license holder that was subject to the prior set-aside decision addressing the individual's quality of care to children or vulnerable adults and the circumstances of the individual's departure from that service.

(c) If an individual who requires a background study for nonemergency medical transportation services under section 245C.03, subdivision 12, was disqualified for a crime or conduct listed under section 245C.15, subdivision 1, and if more than 40 years have passed since the discharge of the sentence imposed, the commissioner may consider granting

a set-aside pursuant to section 245C.22. A request for reconsideration evaluated under this paragraph must include a letter of recommendation from the employer. This paragraph does not apply to a person disqualified based on a violation of sections 243.166; 609.185 to 609.205; 609.25; 609.342 to 609.3453; 609.352; 617.23, subdivision 2, clause (1), or 3, clause (1); 617.246; or 617.247.

(d) When a licensed foster care provider adopts an individual who had received foster care services from the provider for over six months, and the adopted individual is required to receive a background study under section 245C.03, subdivision 1, paragraph (a), clause (2) or (6), the commissioner may grant a variance to the license holder under section 245C.30 to permit the adopted individual with a permanent disqualification to remain affiliated with the license holder under the conditions of the variance when the variance is recommended by the county of responsibility for each of the remaining individuals in placement in the home and the licensing agency for the home.

(e) For an individual 18 years of age or older affiliated with a licensed family foster setting, the commissioner must not set aside or grant a variance for the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraphs (a) and (b).

(f) In connection with a family foster setting license, the commissioner may grant a variance to the disqualification for an individual who is under 18 years of age at the time the background study is submitted.

~~(g) In connection with foster residence settings and children's residential facilities, the commissioner must not set aside or grant a variance for the disqualification of any individual disqualified pursuant to this chapter, regardless of how much time has passed, if the individual was disqualified for a crime or conduct listed in section 245C.15, subdivision 4a, paragraph (a) or (b).~~

Sec. 20. Minnesota Statutes 2024, section 245D.04, subdivision 3, is amended to read:

Subd. 3. **Protection-related rights.** (a) A person's protection-related rights include the right to:

(1) have personal, financial, service, health, and medical information kept private, and be advised of disclosure of this information by the license holder;

(2) access records and recorded information about the person in accordance with applicable state and federal law, regulation, or rule;

(3) be free from maltreatment;

(4) be free from restraint, time out, seclusion, restrictive intervention, or other prohibited procedure identified in section 245D.06, subdivision 5, or successor provisions, except for: (i) emergency use of manual restraint to protect the person from imminent danger to self or others according to the requirements in section 245D.061 or successor provisions; or (ii) the use of safety interventions as part of a positive support transition plan under section 245D.06, subdivision 8, or successor provisions;

(5) receive services in a clean and safe environment when the license holder is the owner, lessor, or tenant of the service site;

(6) be treated with courtesy and respect and receive respectful treatment of the person's property;

(7) reasonable observance of cultural and ethnic practice and religion;

(8) be free from bias and harassment regarding race, gender, age, disability, spirituality, and sexual orientation;

(9) be informed of and use the license holder's grievance policy and procedures, including knowing how to contact persons responsible for addressing problems and to appeal under section 256.045;

(10) know the name, telephone number, and the website, email, and street addresses of protection and advocacy services, including the appropriate state-appointed ombudsman, and a brief description of how to file a complaint with these offices;

(11) assert these rights personally, or have them asserted by the person's family, authorized representative, or legal representative, without retaliation;

(12) give or withhold written informed consent to participate in any research or experimental treatment;

(13) associate with other persons of the person's choice in the community;

(14) personal privacy, including the right to use the lock on the person's bedroom or unit door;

(15) engage in chosen activities; and

(16) access to the person's personal possessions at any time, including financial resources.

(b) For a person residing in a residential site licensed according to chapter 245A, or where the license holder is the owner, lessor, or tenant of the residential service site, protection-related rights also include the right to:

(1) have daily, private access to and use of a non-coin-operated telephone for local calls and long-distance calls made collect or paid for by the person;

(2) receive and send, without interference, uncensored, unopened mail or electronic correspondence or communication;

(3) have use of and free access to common areas in the residence and the freedom to come and go from the residence at will;

(4) choose the person's visitors and time of visits and have privacy for visits with the person's spouse, next of kin, legal counsel, religious adviser, or others, in accordance with section 363A.09 of the Human Rights Act, including privacy in the person's bedroom;

(5) have access to three nutritionally balanced meals and nutritious snacks between meals each day;

(6) have freedom and support to access food and potable water at any time;

(7) have the freedom to furnish and decorate the person's bedroom or living unit;

(8) a setting that is clean and free from accumulation of dirt, grease, garbage, peeling paint, mold, vermin, and insects;

(9) a setting that is free from hazards that threaten the person's health or safety; and

(10) a setting that meets the definition of a dwelling unit within a residential occupancy as defined in the State Fire Code.

(c) Restriction of a person's rights under paragraph (a), clauses (13) to (16), or paragraph (b), clauses (1) to (7), is allowed only if determined necessary to ensure the health, safety, and well-being of the person. Any restriction of those rights must be documented in the person's support plan or support plan addendum. The restriction must be implemented in the least restrictive alternative manner necessary to protect the person and provide support to reduce or eliminate the need for the restriction in the most integrated setting and inclusive manner. The documentation must include the following information:

(1) the justification for the restriction based on an assessment of the person's vulnerability related to exercising the right without restriction;

(2) the objective measures set as conditions for ending the restriction;

(3) a schedule for reviewing the need for the restriction based on the conditions for ending the restriction to occur semiannually from the date of initial approval, at a minimum, or more frequently if requested by the person, the person's legal representative, if any, and case manager; and

(4) signed and dated approval for the restriction from the person, or the person's legal representative, if any. A restriction may be implemented only when the required approval has been obtained. Approval may be withdrawn at any time. If approval is withdrawn, the right must be immediately and fully restored.

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

Sec. 21. Minnesota Statutes 2024, section 245D.10, subdivision 4, is amended to read:

Subd. 4. **Availability of current written policies and procedures.** (a) The license holder must review and update, as needed, the written policies and procedures required under this chapter.

(b)(1) The license holder must inform the person or the person's legal representative and case manager of the policies and procedures affecting a person's rights under section 245D.04, and provide copies of those policies and procedures, within five working days of service initiation.

(2) If a license holder only provides basic services and supports, this includes the:

(i) grievance policy and procedure required under subdivision 2; ~~and~~

(ii) service suspension and termination policy and procedure required under subdivision 3.~~;~~ and

(iii) emergency use of manual restraints policy and procedure required under section 245D.061, subdivision 9, or successor provisions.

(3) For all other license holders this includes the:

(i) policies and procedures in clause (2); and

~~(ii) emergency use of manual restraints policy and procedure required under section 245D.061, subdivision 9, or successor provisions; and~~

~~(iii)~~ (ii) data privacy requirements under section 245D.11, subdivision 3.

(c) The license holder must provide a written notice to all persons or their legal representatives and case managers at least 30 days before implementing any procedural revisions to policies affecting a person's service-related or protection-related rights under

section 245D.04 and maltreatment reporting policies and procedures. The notice must explain the revision that was made and include a copy of the revised policy and procedure. The license holder must document the reasonable cause for not providing the notice at least 30 days before implementing the revisions.

(d) Before implementing revisions to required policies and procedures, the license holder must inform all employees of the revisions and provide training on implementation of the revised policies and procedures.

(e) The license holder must annually notify all persons, or their legal representatives, and case managers of any procedural revisions to policies required under this chapter, other than those in paragraph (c). Upon request, the license holder must provide the person, or the person's legal representative, and case manager with copies of the revised policies and procedures.

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

Sec. 22. Minnesota Statutes 2024, section 256B.02, is amended by adding a subdivision to read:

Subd. 20. **Fraud.** "Fraud" means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in an unauthorized benefit to the person or another person or an act, promise to act, or omission made with the intent to obtain a benefit in a manner that is prohibited. Fraud includes:

(1) submitting an application for provider status knowing that the application misrepresents, conceals, or fails to disclose any material information;

(2) intentionally submitting a claim for reimbursement under this chapter, knowing or having reason to know the claim is ineligible for reimbursement in whole or in part;

(3) providing documentation or other information requested by the commissioner having knowledge that it is false in any material respect; and

(4) any act that constitutes the commission, or attempt or conspiracy to commit, a violation of any of the following:

(i) section 256.98 (wrongfully obtaining assistance);

(ii) section 609.466 (medical assistance fraud);

(iii) section 609.48 (perjury), involving making a false statement related to medical assistance or the receipt of public money;

(iv) section 609.496 (concealing criminal proceeds) or 609.497 (engaging in business of concealing criminal proceeds), involving proceeds consisting of public money;

(v) section 609.52 (theft), involving theft of property consisting of public money;

(vi) section 609.542 (illegal remuneration);

(vii) section 609.625 (aggravated forgery) or 609.63 (forgery), involving falsely filing any record, account, or other document with any state agency or department or falsely making or altering any record, account, or other document filed with any state agency or department;

(viii) section 609.821 (financial transaction card fraud), involving a public assistance benefit;

(ix) a felony listed in United States Code, title 42, section 1320a-7b(b)(1) or (2), subject to any safe harbors established in Code of Federal Regulations, title 42, section 1001.952; and

(x) any other act that constitutes fraud under applicable federal law.

Sec. 23. Minnesota Statutes 2024, section 256B.04, subdivision 10, is amended to read:

Subd. 10. **Investigation of certain claims.** The commissioner must establish by rule general criteria and procedures for the identification and prompt investigation of suspected medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment of claims for services not reasonable or medically necessary, or false statement or representation of material facts by a vendor of medical care~~, and for the imposition of sanctions against a vendor of medical care~~. The commissioner may use both prepayment and postpayment review systems to review claims submitted by vendors. Payment of claims, including payments made after a prepayment review, does not prohibit the commissioner from completing a postpayment claims review and taking additional administrative actions or monetary recovery against a vendor. If it appears to the state agency that a vendor of medical care may have acted in a manner warranting civil or criminal proceedings, it shall so inform the attorney general in writing.

Sec. 24. Minnesota Statutes 2025 Supplement, section 256B.051, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

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

Sec. 25. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon an individual or entity under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to an individual or entity, except a nursing home or convalescent care facility, after notice and

prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

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

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

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

(i) fraud hotline complaints;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) other information required by the commissioner.

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

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

Sec. 26. Minnesota Statutes 2025 Supplement, section 256B.0659, subdivision 21, is amended to read:

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

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

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

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

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

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

(6) a copy of the personal care assistance provider agency's written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety including process for notification and resolution of consumer grievances, identification and prevention of communicable diseases, and employee misconduct;

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

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

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

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

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

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

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

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

(12) documentation that the agency will use the following percentages of revenue generated from the medical assistance rate paid for personal care assistance services for

employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal care assistance choice option and 72.5 percent of revenue from other personal care assistance providers. The revenue generated by the qualified professional and the reasonable costs associated with the qualified professional shall not be used in making this calculation; and

(13) effective May 15, 2010, documentation that the agency does not burden recipients' free exercise of their right to choose service providers by requiring personal care assistants to sign an agreement not to work with any particular personal care assistance recipient or for another personal care assistance provider agency after leaving the agency and that the agency is not taking action on any such agreements or requirements regardless of the date signed.

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

(c) All personal care assistance provider agencies shall require all employees in management and supervisory positions and owners of the agency who are active in the day-to-day management and operations of the agency to complete mandatory training as determined by the commissioner before submitting an application for enrollment of the agency as a provider. All personal care assistance provider agencies shall also require qualified professionals to complete the training required by subdivision 13 before submitting an application for enrollment of the agency as a provider. Employees in management and supervisory positions and owners who are active in the day-to-day operations of an agency who have completed the required training as an employee with a personal care assistance provider agency do not need to repeat the required training if they are hired by another agency, if they have completed the training within the past three years. By September 1, 2010, the required training must be available with meaningful access according to title VI of the Civil Rights Act and federal regulations adopted under that law or any guidance from the United States Health and Human Services Department. The required training must be available online or by electronic remote connection. The required training must provide for competency testing. Personal care assistance provider agency billing staff shall complete training about personal care assistance program financial management. This training is effective July 1, 2009. Any personal care assistance provider agency enrolled before that date shall, if it has not already, complete the provider training within 18 months of July 1, 2009. Any new owners or employees in management and supervisory positions involved

in the day-to-day operations are required to complete mandatory training as a requisite of working for the agency. Personal care assistance provider agencies certified for participation in Medicare as home health agencies are exempt from the training required in this subdivision. When available, Medicare-certified home health agency owners, supervisors, or managers must successfully complete the competency test.

(d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability insurance required by this subdivision must be maintained continuously and purchased new annually. After initial enrollment, a provider must submit proof of bonds and required coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

Sec. 27. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 28. Minnesota Statutes 2024, section 256B.27, subdivision 3, is amended to read:

Subd. 3. **Access to medical records.** The commissioner of human services, with the written consent of the recipient, on file with the local welfare agency, shall be allowed access in the manner and within the time prescribed by the commissioner to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: (a) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or (b) the medical care was medically necessary. ~~When the commissioner is investigating a possible overpayment of Medicaid funds,~~ The commissioner may conduct on-site inspections of any and all vendors and service locations or may request records from a vendor to verify that information submitted to the commissioner is accurate, determine compliance with service delivery and billing requirements, and determine compliance with any other applicable laws or rules. The commissioner must be given immediate access without prior notice to the vendor's office during regular business hours and to documentation and records related to services provided and submission of claims for services provided. The department shall document in writing the need for immediate access to records related to a specific investigation. Denying the commissioner access to records is cause for the vendor's immediate suspension of payment or termination according to section 256B.064. The determination of provision of services not medically necessary shall be made by the commissioner. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to this section.

Sec. 29. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 12, is amended to read:

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

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

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

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

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 30. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 17a, is amended to read:

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

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

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

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

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

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

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

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

(8) comply with medical assistance provider requirements;

(9) understand the CFSS program and its policies;

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

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

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

Sec. 31. Minnesota Statutes 2025 Supplement, section 260E.03, subdivision 6, is amended to read:

Subd. 6. **Facility.** "Facility" means:

(1) a licensed or unlicensed day care facility, certified license-exempt child care center, residential facility, agency, psychiatric residential treatment facility, hospital, sanitarium, or other facility or institution required to be licensed under sections 144.50 to 144.58, 241.021, or 245A.01 to 245A.16, or chapter 142B, 142C, 144H, or 245D;

(2) a school as defined in section 120A.05, subdivisions 9, 11, and 13; and chapter 124E; or

(3) a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a.

Sec. 32. Minnesota Statutes 2025 Supplement, section 260E.11, subdivision 1, is amended to read:

Subdivision 1. **Reports of maltreatment in facility.** A person mandated to report child maltreatment occurring within a licensed facility shall report the information to the agency responsible for licensing or certifying the facility under sections 144.50 to 144.58, 241.021, and 245A.01 to 245A.16 or chapter 142B, 142C, 144H, or 245D or to a nonlicensed personal care provider organization as defined in section 256B.0625, subdivision 19a. A person mandated to report child maltreatment occurring within a federally certified psychiatric residential treatment facility must report the information to the Department of Health.

Sec. 33. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended to read:

Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency responsible for investigating allegations of maltreatment in child foster care, family child care, legally nonlicensed child care, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A and 245D, except federally certified psychiatric residential treatment facilities.

(c) The Department of Health is the agency responsible for screening and investigating allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 ~~or~~, chapter 144H, or federally certified as a psychiatric residential treatment facility.

(d) The Department of Education is the agency responsible for screening and investigating allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E. The Department of Education's responsibility to screen and investigate includes allegations of maltreatment involving students 18 through 21 years of age, including students receiving special education services, up to and including graduation and the issuance of a secondary or high school diploma.

(e) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors in an EIDBI agency operating under sections 245A.142 and 256B.0949.

(f) A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

(g) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in facilities or programs not listed in paragraph (a) that are licensed or certified under chapters 142B and 142C.

Sec. 34. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, federally certified psychiatric residential treatment facilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, EIDBI agencies, family adult day services, mental health programs, mental health clinics, substance use disorder programs, the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services, except federally certified psychiatric residential treatment facilities. The Department of Human Services is also the lead investigative agency for unlicensed EIDBI agencies under section 256B.0949.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including but not limited to reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659.

Sec. 35. **NEW BACKGROUND STUDIES FOR INDIVIDUALS NOT IN NETSTUDY 2.0.**

By March 1, 2027, the commissioner of human services and counties must conduct new background studies for all individuals specified under Minnesota Statutes, section 245C.03, subdivision 1, paragraph (a), clauses (2) to (6), and affiliated with a child foster family setting license holder, adult foster care or family adult day services and with a family child care license holder, or a legal nonlicensed child care provider authorized under Minnesota Statutes, chapter 142E. The commissioner and counties must follow the requirements in Minnesota Statutes, section 245C.04, subdivision 1, paragraphs (e) and (f), when conducting

the background studies under this section. The new background studies must be submitted through NETStudy 2.0.

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

Sec. 36. **REPEALER.**

(a) Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3a, is repealed.

(b) Minnesota Rules, part 9505.2165, subpart 4, is repealed.

EFFECTIVE DATE. Paragraph (a) is effective October 1, 2026.

ARTICLE 3
BACKGROUND STUDIES

Section 1. Minnesota Statutes 2025 Supplement, section 245C.02, subdivision 15a, is amended to read:

Subd. 15a. **Reasonable cause to require a national criminal history record check.** (a) "Reasonable cause to require a national criminal history record check" means information or circumstances exist that provide the commissioner with articulable suspicion that further pertinent information may exist concerning a background study subject that merits conducting a national criminal history record check on that subject. The commissioner has reasonable cause to require a national criminal history record check when:

(1) information from the Bureau of Criminal Apprehension indicates that the subject is a multistate offender;

(2) information from the Bureau of Criminal Apprehension indicates that multistate offender status is undetermined;

(3) the commissioner has received a report from the subject or a third party indicating that the subject has a criminal history in a jurisdiction other than Minnesota; or

(4) information from the Bureau of Criminal Apprehension for a state-based name and date of birth background study in which the subject is a minor that indicates that the subject has a criminal history.

(b) In addition to the circumstances described in paragraph (a), the commissioner has reasonable cause to require a national criminal history record check if the subject is not currently residing in Minnesota or resided in a jurisdiction other than Minnesota during the previous five years.

(c) Reasonable cause to require a national criminal history check does not apply to family child foster care ~~or~~, adoption, adult day services, or adult foster care studies.

EFFECTIVE DATE. This section is effective January 25, 2028.

Sec. 2. Minnesota Statutes 2024, section 245C.03, subdivision 3a, is amended to read:

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

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

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

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

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

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

Sec. 3. Minnesota Statutes 2024, section 245C.03, subdivision 9, is amended to read:

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

(1) owners who have a five percent interest or more, board members, and all managing employees are subject to a background study under this chapter. This requirement applies to currently enrolled providers and agencies seeking enrollment. "Managing employee" has

the meaning given in Code of Federal Regulations, title 42, section 455.101. An organization is barred from enrollment if:

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

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

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

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

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

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

Subd. 17. **Providers of adult rehabilitative mental health services.** The commissioner shall conduct background studies on any individual who is an owner with an ownership stake of at least five percent in an adult rehabilitative mental health services provider, an operator of an adult rehabilitative mental health services provider, or an employee or volunteer who has direct contact with people receiving adult rehabilitative mental health services under section 256B.0623. For the purposes of this subdivision, "operator" includes board members or other individuals who oversee the billing, management, or policies of the services provided.

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

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

Subd. 18. **Providers of peer recovery support services.** The commissioner shall conduct background studies on any individual who is an owner with an ownership stake of at least five percent in a peer recovery support services provider, an operator of a peer recovery support services provider, or an employee or volunteer who has direct contact with people

receiving peer recovery support services under section 254B.052. For the purposes of this subdivision, "operator" includes board members or other individuals who oversee the billing, management, or policies of the services provided.

EFFECTIVE DATE. This section is effective upon implementation in NETStudy 2.0, but no sooner than December 15, 2026.

Sec. 6. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to read:

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

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

Sec. 7. Minnesota Statutes 2025 Supplement, section 245C.05, subdivision 5, is amended to read:

Subd. 5. **Fingerprints and photograph.** (a) Notwithstanding paragraph (c), for background studies conducted by the commissioner for current or prospective child foster or adoptive parents, and for any adult working in a children's residential facility, the subject of the background study shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency for a national criminal history record check.

(b) Notwithstanding paragraph (c), for background studies conducted by the commissioner for Head Start programs, the subject of the background study shall provide the commissioner with a set of classifiable fingerprints obtained from an authorized agency for a national criminal history record check.

(c) For background studies initiated on or after the implementation of NETStudy 2.0, except as provided under subdivision 5a, every subject of a background study must provide the commissioner with a set of the background study subject's classifiable fingerprints and photograph. The photograph and fingerprints must be recorded at the same time by the

authorized fingerprint collection vendor or vendors and sent to the commissioner through the commissioner's secure data system described in section 245C.32, subdivision 1a, paragraph (b).

(d) The fingerprints shall be submitted by the commissioner to the Bureau of Criminal Apprehension and, when specifically required by law, submitted to the Federal Bureau of Investigation for a national criminal history record check.

(e) The fingerprints must not be retained by the Department of Public Safety, Bureau of Criminal Apprehension, or the commissioner. The Federal Bureau of Investigation will not retain background study subjects' fingerprints.

(f) The authorized fingerprint collection vendor or vendors shall, for purposes of verifying the identity of the background study subject, be able to view the identifying information entered into NETStudy 2.0 by the entity that initiated the background study, but shall not retain the subject's fingerprints, photograph, or information from NETStudy 2.0. The authorized fingerprint collection vendor or vendors shall retain no more than the name and date and time the subject's fingerprints were recorded and sent, only as necessary for auditing and billing activities.

(g) For any background study conducted under this chapter, except for family child foster care ~~or~~, adoption, adult day services, or adult foster care studies, the subject shall provide the commissioner with a set of classifiable fingerprints when the commissioner has reasonable cause to require a national criminal history record check as defined in section 245C.02, subdivision 15a.

EFFECTIVE DATE. This section is effective January 25, 2028.

Sec. 8. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended to read:

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

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

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

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of

the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study. When more time is necessary to complete a background study of an individual affiliated with a Title IV-E eligible children's residential facility or foster residence setting, the individual may not work in the facility or setting regardless of whether or not the individual is supervised;

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

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

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

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

(1) being issued a license;

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

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

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

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

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

(7) for background studies affiliated with a personal care provider organization, ~~except as provided in section 245C.03, subdivision 3b,~~ early intensive developmental and behavioral intervention provider, housing support or supplementary services provider, special

transportation services provider, or community first services and supports provider before ~~a personal care assistant~~ an individual provides services, the ~~personal care assistance provider agency~~ entity must initiate a background study of the ~~personal care assistant~~ individual under this chapter and the ~~personal care assistance provider agency~~ entity must have received a notice from the commissioner that the ~~personal care assistant~~ individual is:

(i) not disqualified under section 245C.14; or

(ii) disqualified, but the ~~personal care assistant~~ individual has received a set aside of the disqualification under section 245C.22~~; or~~.

~~(8) for background studies affiliated with an early intensive developmental and behavioral intervention provider, before an individual provides services, the early intensive developmental and behavioral intervention provider must initiate a background study for the individual under this chapter and the early intensive developmental and behavioral intervention provider must have received a notice from the commissioner that the individual is:~~

~~(i) not disqualified under section 245C.14; or~~

~~(ii) disqualified, but the individual has received a set-aside of the disqualification under section 245C.22.~~

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

Sec. 9. Minnesota Statutes 2025 Supplement, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside;

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program and from working in a children's residential facility or foster residence setting; and

(9) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 2, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense during the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with or access to persons receiving services from the center and from working in a licensed child care center or certified license-exempt child care center.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

(d) This section does not apply to a background study related to an initial application for a child foster family setting license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section ~~256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1, or to a background study for an individual providing early intensive developmental and behavioral intervention services under section 256B.0949~~ 245C.13, subdivision 2, paragraph (c), clause (7).

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised

or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

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

ARTICLE 4
BEHAVIORAL HEALTH

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

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

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

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

(3) is not a jail or prison;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 2. **[256B.0618] COVERAGE FOR DETAINED INDIVIDUALS.**

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

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

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

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

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

(b) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the

eligibility requirements in section 256B.056 is not eligible for medical assistance, except for covered medical assistance services received:

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

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

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

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

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

Sec. 3. **[256B.0619] CARCERAL TARGETED CASE MANAGEMENT SERVICES.**

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

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

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

(c) "Consultation" means communication from a carceral targeted case manager to other providers working with the same justice-involved individual to (1) inform, inquire, and instruct providers on the individual's symptoms, strategies for effective engagement, care and intervention needs, and treatment expectations across service settings, and (2) direct and coordinate clinical service components provided to the justice-involved individual. Service settings and components include but are not limited to education services, social services, probation, an individual's home, primary care, medication prescribers, disabilities services, and services from other mental health providers.

(d) "Targeted case management for justice-involved individuals" means the provision of both county targeted case management and public or private vendor service coordination

services to bridge prerelease and postrelease medical assistance services that support the physical, behavioral, and health-related social needs of justice-involved individuals.

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

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

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

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

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

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

(b) Carceral targeted case management care coordination includes:

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

(2) comprehensive care plans, including but not limited to:

(i) the desired goals of the individual;

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

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

(iv) housing arrangements postrelease;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(9) have a procedure that:

(i) notifies the recipient of any conflict of interest if the targeted case management service provider also provides the recipient's services and supports;

(ii) provides information on all potential conflicts of interest;

(iii) obtains the recipient's informed consent; and

(iv) provides the recipient with alternatives; and

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

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

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

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

Sec. 4. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

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

Sec. 5. Minnesota Statutes 2024, section 256B.0761, subdivision 2, is amended to read:

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

Sec. 6. Laws 2025, First Special Session chapter 9, article 4, section 2, the effective date, is amended to read:

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

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

Sec. 7. Laws 2025, First Special Session chapter 9, article 4, section 23, the effective date, is amended to read:

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

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

Sec. 8. Laws 2025, First Special Session chapter 9, article 4, section 38, the effective date, is amended to read:

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

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

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

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

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

Sec. 10. Laws 2025, First Special Session chapter 9, article 4, section 40, the effective date, is amended to read:

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

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

Sec. 11. Laws 2025, First Special Session chapter 9, article 4, section 41, the effective date, is amended to read:

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

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

Sec. 12. Laws 2025, First Special Session chapter 9, article 4, section 42, the effective date, is amended to read:

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

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 13. Laws 2025, First Special Session chapter 9, article 4, section 43, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 14. Laws 2025, First Special Session chapter 9, article 4, section 44, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 15. Laws 2025, First Special Session chapter 9, article 4, section 50, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~January~~ July 1, ~~2027~~ 2026.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 16. Laws 2025, First Special Session chapter 9, article 4, section 51, is amended to read:

Sec. 51. **RECOVERY RESIDENCE WORK GROUP.**

(a) The commissioner of human services must convene a work group to develop recommendations specific to recovery residences. The work group must:

(1) produce a report that examines how other states fund recovery residences, identifying best practices and models that could be applicable to Minnesota;

(2) engage with stakeholders to ensure meaningful collaboration with key external stakeholders on the ideas being developed that will inform the final plan and recommendations; and

(3) create an implementable plan addressing housing needs for individuals in outpatient substance use disorder treatment that includes:

(i) clear strategies for aligning housing models with individual treatment needs;

(ii) an assessment of funding streams, including potential federal funding sources;

(iii) a timeline for implementation with key milestones and action steps;

(iv) recommendations for future resource allocation to ensure long-term housing stability for individuals in recovery;

(v) specific recommendations for policy or legislative changes that may be required to support sustainable recovery housing solutions, including challenges faced by recovery residences resulting from state and local housing regulations and ordinances; and

(vi) recommendations for potentially delegating the commissioner's recovery residence certification duties under Minnesota Statutes, sections 254B.21 to 254B.216 to a third-party organization.

(b) The work group must include but is not limited to:

(1) at least two designees from the Department of Human Services representing: (i) behavioral health; and (ii) homelessness and housing and support services;

(2) the commissioner of health or a designee;

(3) two people who have experience living in a recovery residence;

(4) representatives from at least three substance use disorder lodging facilities currently operating in Minnesota;

(5) three representatives from county social services agencies, at least one from inside the seven-county metropolitan area and one from outside the seven-county metropolitan area;

(6) a representative from a Tribal social services agency;

(7) representatives from the state affiliate of the National Alliance for Recovery Residences; and

(8) representatives from state mental health advocacy and adult mental health provider organizations.

(c) The work group must meet at least monthly and as necessary to fulfill its responsibilities. The commissioner of human services must provide administrative support and meeting space for the work group. The work group may conduct meetings remotely.

(d) The commissioner of human services must make appointments to the work group by October 1, 2025, and convene the first meeting of the work group by January 15, 2026.

(e) The work group must submit a final report with recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance on or before ~~January~~ July 1, ~~2027~~ 2026.

Sec. 17. **DIRECTION TO COMMISSIONER; CARCERAL TARGETED CASE MANAGEMENT SERVICES BILLING UNITS.**

The commissioner of human services must establish a new billing code for carceral targeted case management services. The commissioner must identify reimbursement rates for the newly defined codes, as required under Minnesota Statutes, section 256B.0619, subdivision 6. The new billing codes must correspond to a 15-minute unit and must be available for 180 days postrelease.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later.

Sec. 18. **REPEALER.**

Minnesota Statutes 2024, section 256B.055, subdivision 14, is repealed.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later.

ARTICLE 5
UNIFORM SERVICE STANDARDS

Section 1. Minnesota Statutes 2024, section 245.735, subdivision 6, is amended to read:

Subd. 6. **Section 223 of the Protecting Access to Medicare Act entities.** ~~(a) The commissioner must request federal approval to participate in the demonstration program established by section 223 of the Protecting Access to Medicare Act and, if approved, to continue to participate in the demonstration program as long as federal funding for the demonstration program remains available from the United States Department of Health and Human Services. To the extent practicable, the commissioner shall align the requirements of the demonstration program with the requirements under this section for CCBHCs receiving medical assistance reimbursement under the authority of the state's Medicaid state plan. A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.~~

~~(b) The commissioner must follow federal payment guidance, including payment of the CCBHC daily bundled rate for services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. Services provided by a CCBHC operating under the authority of the state's Medicaid state plan will not receive the prospective payment system rate for services rendered by~~

~~CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service.~~

~~(c)~~ Payment for services rendered by CCBHCs to individuals who have commercial insurance as the primary payer and medical assistance as secondary payer is subject to the requirements under section 256B.37. Services provided by a CCBHC operating under the authority of the 223 demonstration or the state's Medicaid state plan will not receive the prospective payment system rate for services rendered by CCBHCs to individuals who have commercial insurance as the primary payer and medical assistance as the secondary payer.

Sec. 2. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 2, is amended to read:

Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

(1) residential or nonresidential programs that are provided to a person by an individual who is related;

(2) nonresidential programs that are provided by an unrelated individual to persons from a single related family;

(3) residential or nonresidential programs that are provided to adults who do not misuse substances or have a substance use disorder, a mental illness, a developmental disability, a functional impairment, or a physical disability;

(4) sheltered workshops or work activity programs that are certified by the commissioner of employment and economic development;

(5) programs operated by a public school for children 33 months or older;

(6) nonresidential programs primarily for children that provide care or supervision for periods of less than three hours a day while the child's parent or legal guardian is in the same building as the nonresidential program or present within another building that is directly contiguous to the building in which the nonresidential program is located;

(7) nursing homes or hospitals licensed by the commissioner of health except as specified under section 245A.02;

(8) board and lodge facilities licensed by the commissioner of health that do not provide children's residential services under Minnesota Rules, chapter 2960, mental health or substance use disorder treatment;

(9) programs licensed by the commissioner of corrections;

(10) recreation programs for children or adults that are operated or approved by a park and recreation board whose primary purpose is to provide social and recreational activities;

(11) noncertified boarding care homes unless they provide services for five or more persons whose primary diagnosis is mental illness or a developmental disability;

(12) programs for children such as scouting, boys clubs, girls clubs, and sports and art programs, and nonresidential programs for children provided for a cumulative total of less than 30 days in any 12-month period;

(13) residential programs for persons with mental illness, that are located in hospitals;

(14) camps licensed by the commissioner of health under Minnesota Rules, chapter 4630;

(15) mental health outpatient services for adults with mental illness or children with mental illness, except, effective January 1, 2028, for programs licensed under section 245A.044;

(16) residential programs serving school-age children whose sole purpose is cultural or educational exchange, until the commissioner adopts appropriate rules;

(17) community support services programs as defined in section 245.462, subdivision 6, and family community support services as defined in section 245.4871, subdivision 17;

(18) assisted living facilities licensed by the commissioner of health under chapter 144G;

(19) substance use disorder treatment activities of licensed professionals in private practice as defined in section 245G.01, subdivision 17;

(20) consumer-directed community support service funded under the Medicaid waiver for persons with developmental disabilities when the individual who provided the service is:

(i) the same individual who is the direct payee of these specific waiver funds or paid by a fiscal agent, fiscal intermediary, or employer of record; and

(ii) not otherwise under the control of a residential or nonresidential program that is required to be licensed under this chapter when providing the service;

(21) a county that is an eligible vendor under section 254B.0501 to provide care coordination and comprehensive assessment services;

(22) a recovery community organization that is an eligible vendor under section 254B.0501 to provide peer recovery support services; or

(23) programs licensed by the commissioner of children, youth, and families in chapter 142B.

(b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a building in which a nonresidential program is located if it shares a common wall with the building in which the nonresidential program is located or is attached to that building by skyway, tunnel, atrium, or common roof.

(c) Except for the home and community-based services identified in section 245D.03, subdivision 1, nothing in this chapter shall be construed to require licensure for any services provided and funded according to an approved federal waiver plan where licensure is specifically identified as not being a condition for the services and funding.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 3. **[245A.044] LICENSED NONRESIDENTIAL BEHAVIORAL HEALTH SERVICES.**

Subdivision 1. **License required for certain nonresidential behavioral health services.** (a) Beginning January 1, 2028, providers of nonresidential mental health and substance use disorder services must obtain a license under this chapter to provide:

(1) adult rehabilitative mental health services under section 245I.22;

(2) children's therapeutic services and supports in the community under section 245I.30 and children's day treatment under section 245I.31;

(3) crisis response services under section 245I.24; and

(4) certified community behavioral health clinic services under section 245I.17.

(b) As a condition of licensure, an applicant or license holder must demonstrate and maintain verification of compliance with:

(1) licensing requirements under this chapter and chapter 245I; and

(2) applicable health care program requirements under Minnesota Rules, parts 9505.0170 to 9505.0475 and 9505.2160 to 9505.2245.

Subd. 2. **Implementation.** (a) Beginning July 1, 2027, the commissioner must begin issuing licenses to providers listed in subdivision 1. The commissioner must transition providers certified under section 245I.011 and listed in subdivision 1 into licensure with a phased-in schedule determined by the commissioner. The commissioner must communicate

the implementation schedule to providers at least three months before the application is made available.

(b) Applicants for licensure must have an approved certification under section 245I.011 at least 90 days before the date of the licensure application.

(c) A provider's certification under section 245I.011, subdivision 5, paragraph (a), clauses (2) to (4), or 6, paragraph (b), expires when the commissioner issues a decision on the provider's license application.

(d) Upon licensure, a license holder must notify clients and staff of policies and procedures outlined in the application.

(e) Notwithstanding paragraphs (a) and (c), subdivision 1, and sections 245I.17, 245I.22, 245I.24, 245I.30, and 245I.31, a provider listed under subdivision 1, paragraph (a), clauses (1) to (4), and certified under section 245I.011 may continue operating past January 1, 2028, until the commissioner issues a licensing decision if the provider submitted an application before January 1, 2028.

(f) If a provider fails to submit an application for licensure within the time frame in paragraph (b), the commissioner must disenroll the provider from reimbursement for the following services:

(1) adult rehabilitative mental health services under section 256B.0623;

(2) crisis response services under section 256B.0624;

(3) children's therapeutic services and supports under section 256B.0943; and

(4) certified community behavioral health clinics under section 256B.0625, subdivision 5m.

(g) The commissioner must disenroll a provider listed in paragraph (f) from medical assistance if:

(1) the provider's licensing application has been denied or the license has been suspended or revoked; and

(2) the provider appealed the application denial or the license suspension or revocation, and the commissioner issued a final order on the appeal affirming the action.

EFFECTIVE DATE. This section is effective July 1, 2026.

Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3, is amended to read:

Subd. 3. **Application fee for initial license or certification.** (a) Except as provided in paragraphs (c) ~~and~~, (d), and (f), for fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner shall submit a $2,100 application fee with each new application required under this subdivision. The application fee shall not be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that expires on December 31. The commissioner shall not process an application until the application fee is paid.

(b) Except as provided in paragraph (c), an applicant shall apply for a license to provide services at a specific location.

(c) For a license to provide home and community-based services to persons with disabilities or age 65 and older under chapter 245D, an applicant shall submit an application to provide services statewide. For fees required under subdivision 1, an applicant for an initial license issued by the commissioner to provide home and community-based services under chapter 245D shall submit a $4,200 application fee with each new application.

(d) For fees required under subdivision 1, an applicant for an initial license or certification issued by the commissioner for children's residential facility ~~or mental health clinic licensure or certification~~ shall submit a $500 application fee with each new application required under this subdivision.

(e) For fees required under subdivision 1, an applicant for an initial mental health clinic certification issued by the commissioner shall submit a $2,100 application fee with each new application required under this subdivision.

(f) For fees required under subdivision 1, an applicant for an initial license issued by the commissioner to provide services at a certified community behavioral health clinic under section 245I.17 shall submit a $4,200 application fee with each new application.

Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended to read:

Subd. 4. **License or certification fee for certain programs.** (a)(1) A program licensed to provide one or more of the home and community-based services and supports identified under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual nonrefundable license fee based on revenues derived from the provision of services that

would require licensure under chapter 245D during the calendar year immediately preceding the year in which the license fee is paid, according to the following schedule:

License Holder Annual Revenue	License Fee
less than or equal to $10,000	$250
greater than $10,000 but less than or equal to $25,000	$375
greater than $25,000 but less than or equal to $50,000	$500
greater than $50,000 but less than or equal to $100,000	$625
greater than $100,000 but less than or equal to $150,000	$750
greater than $150,000 but less than or equal to $200,000	$1,000
greater than $200,000 but less than or equal to $250,000	$1,250
greater than $250,000 but less than or equal to $300,000	$1,500
greater than $300,000 but less than or equal to $350,000	$1,750
greater than $350,000 but less than or equal to $400,000	$2,000
greater than $400,000 but less than or equal to $450,000	$2,250
greater than $450,000 but less than or equal to $500,000	$2,500
greater than $500,000 but less than or equal to $600,000	$2,850
greater than $600,000 but less than or equal to $700,000	$3,200
greater than $700,000 but less than or equal to $800,000	$3,600
greater than $800,000 but less than or equal to $900,000	$3,900
greater than $900,000 but less than or equal to $1,000,000	$4,250
greater than $1,000,000 but less than or equal to $1,250,000	$4,550
greater than $1,250,000 but less than or equal to $1,500,000	$4,900
greater than $1,500,000 but less than or equal to $1,750,000	$5,200
greater than $1,750,000 but less than or equal to $2,000,000	$5,500

greater than $2,000,000 but less than or equal to $2,500,000	$5,900
greater than $2,500,000 but less than or equal to $3,000,000	$6,200
greater than $3,000,000 but less than or equal to $3,500,000	$6,500
greater than $3,500,000 but less than or equal to $4,000,000	$7,200
greater than $4,000,000 but less than or equal to $4,500,000	$7,800
greater than $4,500,000 but less than or equal to $5,000,000	$9,000
greater than $5,000,000 but less than or equal to $7,500,000	$10,000
greater than $7,500,000 but less than or equal to $10,000,000	$14,000
greater than $10,000,000 but less than or equal to $12,500,000	$18,000
greater than $12,500,000 but less than or equal to $15,000,000	$25,000
greater than $15,000,000 but less than or equal to $17,500,000	$28,000
greater than $17,500,000 but less than $20,000,000	$32,000
greater than $20,000,000 but less than $25,000,000	$36,000
greater than $25,000,000 but less than $30,000,000	$45,000
greater than $30,000,000 but less than $35,000,000	$55,000
greater than $35,000,000	$75,000

(2) If requested, the license holder shall provide the commissioner information to verify the license holder's annual revenues or other information as needed, including copies of documents submitted to the Department of Revenue.

(3) At each annual renewal, a license holder may elect to pay the highest renewal fee, and not provide annual revenue information to the commissioner.

(4) A license holder that knowingly provides the commissioner incorrect revenue amounts for the purpose of paying a lower license fee shall be subject to a civil penalty in the amount of double the fee the provider should have paid.

(b) A substance use disorder treatment program licensed under chapter 245G, to provide substance use disorder treatment shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 to 74 persons	$5,000
75 to 99 persons	$10,000
100 to 199 persons	$15,000
200 or more persons	$20,000

(c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 or more persons	$5,000

A detoxification program that also operates a withdrawal management program at the same location shall only pay one fee based upon the licensed capacity of the program with the higher overall capacity.

(d) A children's residential facility licensed under Minnesota Rules, chapter 2960, to serve children shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

(e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600

25 to 49 persons	$3,000
50 or more persons	$20,000

(f) A residential facility licensed under Minnesota Rules, parts 9570.2000 to 9570.3400, to serve persons with physical disabilities shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$450
25 to 49 persons	$650
50 to 74 persons	$850
75 to 99 persons	$1,050
100 or more persons	$1,250

(g) A program licensed as an adult day care center licensed under Minnesota Rules, parts 9555.9600 to 9555.9730, shall pay an annual nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600
25 to 49 persons	$3,000
50 to 74 persons	$5,000
75 to 99 persons	$10,000
100 to 199 persons	$15,000
200 or more persons	$20,000

(h) A program licensed to provide treatment services to persons with sexual psychopathic personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

(i) A mental health clinic certified under section 245I.20 shall pay an annual nonrefundable certification fee of ~~$1,550~~ $3,000. If the mental health clinic provides services at a primary location with satellite facilities, the satellite facilities shall be certified with the primary location without an additional charge.

~~(j) If a program subject to annual fees under paragraph (b) provides services at a primary location with satellite facilities, the satellite facilities must be licensed with the primary location and must be subject to an additional $500 annual nonrefundable license fee per satellite facility.~~

(j) A program licensed to provide behavioral health treatment services licensed under section 245I.22, 245I.24, 245I.30, or 245I.31 shall pay an annual nonrefundable license fee of $3,000 for each license.

(k) Certified community behavioral health clinics licensed under section 245I.17 shall pay an annual nonrefundable license fee of $7,800.

Sec. 6. Minnesota Statutes 2024, section 245A.10, is amended by adding a subdivision to read:

Subd. 4a. **Fees for satellite locations.** (a) If a program subject to annual fees under subdivision 4, paragraph (b), provides services at a primary location with satellite facilities, the satellite facilities are licensed with the primary location and are subject to an additional $500 annual nonrefundable license fee per satellite facility.

(b) If a program subject to annual fees under subdivision 4, paragraph (j), provides services at a primary location with satellite sites or facilities, the satellite locations must be licensed with the primary location and are subject to an additional annual nonrefundable fee according to the following schedule:

(1) one to five satellite locations: $1,500;

(2) six to 19 satellite locations: $3,500; or

(3) 20 or more satellite locations: $5,000.

Sec. 7. Minnesota Statutes 2024, section 245A.65, subdivision 1a, is amended to read:

Subd. 1a. **Determination of vulnerable adult status.** (a) A license holder that provides services to adults who are excluded from the definition of vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (2), must determine whether the person is a vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (4). This determination must be made within 24 hours of:

(1) admission to the licensed program; and

(2) any incident that:

(i) was reported under section 626.557; or

(ii) would have been required to be reported under section 626.557, if one or more of the adults involved in the incident had been vulnerable adults.

(b) Upon determining that a person receiving services is a vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (4), all requirements relative to vulnerable adults under this chapter and section 626.557 must be met by the license holder.

(c) Notwithstanding paragraph (a), clause (1), a license holder providing mobile crisis services must make the required determination within 24 hours of first providing crisis stabilization services to an adult under section 245I.24, subdivision 9.

Sec. 8. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

Subdivision 1. **Programs licensed by the commissioner.** (a) The commissioner shall conduct a background study on:

(1) the person or persons applying for a license;

(2) an individual age 13 and over living in the household where the licensed program will be provided who is not receiving licensed services from the program;

(3) current or prospective employees of the applicant or license holder who will have direct contact with persons served by the facility, agency, or program;

(4) volunteers or student volunteers who will have direct contact with persons served by the program to provide program services if the contact is not under the continuous, direct supervision by an individual listed in clause (1) or (3);

(5) an individual age ten to 12 living in the household where the licensed services will be provided when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15;

(6) an individual who, without providing direct contact services at a licensed program, may have unsupervised access to children or vulnerable adults receiving services from a program, when the commissioner has reasonable cause as defined in section 245C.02, subdivision 15; and

(7) all controlling individuals as defined in section 245A.02, subdivision 5a;

(8) notwithstanding clause (3), for children's residential facilities and foster residence settings, any adult working in the facility, whether or not the individual will have direct contact with persons served by the facility.

(b) For child foster care when the license holder resides in the home where foster care services are provided, a short-term substitute caregiver providing direct contact services for a child for less than 72 hours of continuous care is not required to receive a background study under this chapter.

(c) This subdivision applies to the following programs that must be licensed under chapter 245A:

(1) adult foster care;

(2) children's residential facilities;

(3) licensed home and community-based services under chapter 245D;

(4) residential mental health programs for adults;

(5) substance use disorder treatment programs under chapter 245G;

(6) withdrawal management programs under chapter 245F;

(7) adult day care centers;

(8) family adult day services;

(9) detoxification programs;

(10) community residential settings;

(11) intensive residential treatment services and residential crisis stabilization under chapter 245I; ~~and~~

(12) treatment programs for persons with sexual psychopathic personality or sexually dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts 9515.3000 to 9515.3110~~.~~;

(13) adult rehabilitative mental health services under chapter 245I;

(14) certified community behavioral health clinic services under chapter 245I;

(15) children's therapeutic services and supports under chapter 245I; and

(16) crisis response services under chapter 245I.

Sec. 9. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended to read:

Subd. 2. **Activities pending completion of background study.** The subject of a background study may not perform any activity requiring a background study under paragraph (c) until the commissioner has issued one of the notices under paragraph (a).

(a) Notices from the commissioner required prior to activity under paragraph (c) include:

(1) a notice of the study results under section 245C.17 stating that:

(i) the individual is not disqualified; or

(ii) more time is needed to complete the study but the individual is not required to be removed from direct contact or access to people receiving services prior to completion of the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice that more time is needed to complete the study must also indicate whether the individual is required to be under continuous direct supervision prior to completion of the background study. When more time is necessary to complete a background study of an individual affiliated with a Title IV-E eligible children's residential facility or foster residence setting, the individual may not work in the facility or setting regardless of whether or not the individual is supervised;

(2) a notice that a disqualification has been set aside under section 245C.23; or

(3) a notice that a variance has been granted related to the individual under section 245C.30.

(b) For a background study affiliated with a licensed child care center or certified license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii), must not be issued until the commissioner receives a qualifying result for the individual for the fingerprint-based national criminal history record check or the fingerprint-based criminal history information from the Bureau of Criminal Apprehension. The notice must require the individual to be under continuous direct supervision prior to completion of the remainder of the background study except as permitted in subdivision 3.

(c) Activities prohibited prior to receipt of notice under paragraph (a) include:

(1) being issued a license;

(2) living in the household where the licensed program will be provided;

(3) providing direct contact services to persons served by a program unless the subject is under continuous direct supervision;

(4) having access to persons receiving services if the background study was completed under section 144.057, subdivision 1, or 245C.03, subdivision 1, paragraph (a), clause (2), (5), or (6), unless the subject is under continuous direct supervision;

(5) for licensed child care centers and certified license-exempt child care centers, providing direct contact services to persons served by the program;

(6) for children's residential facilities or foster residence settings, working in the facility or setting;

(7) for background studies affiliated with a personal care provider organization, except as provided in section 245C.03, subdivision 3b, or with an early intensive developmental and behavioral intervention provider or adult rehabilitative mental health services provider, before ~~a personal care assistant~~ an individual provides services, the ~~personal care assistance provider agency~~ entity must initiate a background study of the ~~personal care assistant~~ individual under this chapter and the ~~personal care assistance provider agency~~ entity must have received a notice from the commissioner that the ~~personal care assistant~~ individual is:

(i) not disqualified under section 245C.14; or

(ii) disqualified, but the personal care assistant has received a set aside of the disqualification under section 245C.22; or

(8) for background studies affiliated with an early intensive developmental and behavioral intervention provider, before an individual provides services, the early intensive developmental and behavioral intervention provider must initiate a background study for the individual under this chapter and the early intensive developmental and behavioral intervention provider must have received a notice from the commissioner that the individual is:

(i) not disqualified under section 245C.14; or

(ii) disqualified, but the individual has received a set-aside of the disqualification under section 245C.22.

Sec. 10. Minnesota Statutes 2025 Supplement, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review the information immediately available and make a determination as to the subject's immediate risk of harm to persons served by the program where the individual studied will have direct contact with, or access to, people receiving services.

(b) The commissioner shall consider all relevant information available, including the following factors in determining the immediate risk of harm:

(1) the recency of the disqualifying characteristic;

(2) the recency of discharge from probation for the crimes;

(3) the number of disqualifying characteristics;

(4) the intrusiveness or violence of the disqualifying characteristic;

(5) the vulnerability of the victim involved in the disqualifying characteristic;

(6) the similarity of the victim to the persons served by the program where the individual studied will have direct contact;

(7) whether the individual has a disqualification from a previous background study that has not been set aside;

(8) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 1, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense in the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with, or access to, persons receiving services from the program and from working in a children's residential facility or foster residence setting; and

(9) if the individual has a disqualification which may not be set aside because it is a permanent bar under section 245C.24, subdivision 2, or the individual is a child care background study subject who has a felony-level conviction for a drug-related offense during the last five years, the commissioner may order the immediate removal of the individual from any position allowing direct contact with or access to persons receiving services from the center and from working in a licensed child care center or certified license-exempt child care center.

(c) This section does not apply when the subject of a background study is regulated by a health-related licensing board as defined in chapter 214, and the subject is determined to be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

(d) This section does not apply to a background study related to an initial application for a child foster family setting license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section ~~256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1, or to a background study for an individual providing early intensive developmental and behavioral intervention services under section 256B.0949~~ 245C.13, subdivision 2, paragraph (c), clause (7).

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised

or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

Sec. 11. Minnesota Statutes 2024, section 245G.03, subdivision 1, is amended to read:

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in section 626.557; chapters 245A, 245C, and 260E; and Minnesota Rules, chapter 9544.

(b) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

(c) If a program is licensed according to this chapter and is part of a certified community behavioral health clinic under section ~~245.735~~ 245I.17, the license holder must comply with the requirements in section ~~245.735~~ 245I.17, subdivisions ~~4b to 4e~~ 12 and 13, as part of the licensing requirements under this chapter.

Sec. 12. Minnesota Statutes 2024, section 245I.011, subdivision 3, is amended to read:

Subd. 3. **Certification required.** (a) An individual, organization, or government entity that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause ~~(12)~~ (15), and chooses to be identified as a certified mental health clinic must:

(1) be a mental health clinic that is certified under section 245I.20;

(2) comply with all of the responsibilities assigned to a license holder by this chapter except subdivision 1; and

(3) comply with all of the responsibilities assigned to a certification holder by chapter 245A.

(b) An individual, organization, or government entity described by this subdivision must obtain a criminal background study for each staff person or volunteer who provides direct contact services to clients.

~~(c) If a clinic is certified according to this chapter and is part of a certified community behavioral health clinic under section 245.735, the license holder must comply with the requirements in section 245.735, subdivisions 4b to 4e, as part of the licensing requirements under this chapter.~~

EFFECTIVE DATE. This section is effective the day following final enactment, except the amendment striking paragraph (c) is effective January 1, 2028.

Sec. 13. Minnesota Statutes 2024, section 245I.011, subdivision 5, is amended to read:

Subd. 5. **Programs certified under chapter 256B.** (a) An individual, organization, or government entity certified under the following sections must comply with all of the responsibilities assigned to a license holder under this chapter except subdivision 1:

(1) an assertive community treatment provider under section 256B.0622, subdivision 3a;

~~(2) an adult rehabilitative mental health services provider under section 256B.0623;~~

~~(3) a mobile crisis team under section 256B.0624;~~

~~(4) a children's therapeutic services and supports provider under section 256B.0943;~~

~~(5)~~ (2) a children's intensive behavioral health services provider under section 256B.0946; and

~~(6)~~ (3) an intensive nonresidential rehabilitative mental health services provider under section 256B.0947.

(b) An individual, organization, or government entity certified under the sections listed in paragraph (a)~~, clauses (1) to (6),~~ must obtain a criminal background study for each staff person and volunteer providing direct contact services to a client.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 14. Minnesota Statutes 2024, section 245I.011, is amended by adding a subdivision to read:

Subd. 6. **License required for nonresidential programs.** (a) Beginning January 1, 2028, an individual, organization, or government entity must have a license under this chapter to provide the following services:

(1) adult rehabilitative mental health services, as defined in section 256B.0623;

(2) mobile crisis services, as defined in section 256B.0624;

(3) children's therapeutic services and supports, as defined in section 256B.0943; or

(4) certified community behavioral health clinic services, as defined in sections 245I.17 and 256B.0625, subdivision 5m.

(b) An individual, organization, or government entity certified as any of the following must remain certified according to subdivision 5 until the commissioner issues a license,

the commissioner denies the license application, or the certification expires according to chapter 245A:

(1) an adult rehabilitative mental health services provider under section 256B.0623;

(2) a mobile crisis team under section 256B.0624;

(3) a children's therapeutic services and supports provider under section 256B.0943; or

(4) a certified community behavioral health clinic under section 245.735.

Sec. 15. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

Subd. 1a. **Alcohol and drug counselor** "Alcohol and drug counselor" means an individual qualified under section 245G.11, subdivision 5.

Sec. 16. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

Subd. 10a. **Comprehensive evaluation.** "Comprehensive evaluation" means a person-centered, family-centered, and trauma-informed evaluation conducted according to section 245I.17, subdivision 12.

Sec. 17. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

Subd. 18a. **Initial evaluation.** "Initial evaluation" means the assessment and preliminary diagnosis necessary to begin client services, conducted according to section 245I.17.

Sec. 18. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

Subd. 31a. **Psychotherapy.** "Psychotherapy" has the meaning given in section 256B.0671, subdivision 11.

Sec. 19. Minnesota Statutes 2024, section 245I.02, subdivision 33, is amended to read:

Subd. 33. **Rehabilitative mental health services.** "Rehabilitative mental health services" means mental health services provided to ~~an adult~~ a client that enable the client to develop and achieve psychiatric stability, social competencies, personal and emotional adjustment, independent living skills, family roles, and community skills when symptoms of mental illness has impaired any of the client's abilities in these areas. Rehabilitative mental health

services include interventions that allow a client to self-monitor, compensate for, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a mental illness. For a child client, rehabilitative mental health services include interventions to restore a child or adolescent to an age-appropriate developmental trajectory that has been disrupted by a mental illness.

Sec. 20. Minnesota Statutes 2024, section 245I.02, subdivision 39, is amended to read:

Subd. 39. **Treatment plan.** "Treatment plan" means services that a license holder formulates to respond to a client's needs and goals. A treatment plan includes individual treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision 8, and 256B.0624, subdivision 11. For a license holder under section 245I.17, a treatment plan is the integrated treatment plan developed according to section 245I.17, subdivision 13.

Sec. 21. Minnesota Statutes 2024, section 245I.03, subdivision 4, is amended to read:

Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each staff person follows when responding to a client who exhibits behavior that threatens the immediate safety of the client or others. A license holder's behavioral emergency procedures must incorporate person-centered planning and trauma-informed care.

(b) A license holder's behavioral emergency procedures must include:

(1) a plan designed to prevent the client from inflicting self-harm and harming others;

(2) contact information for emergency resources that a staff person must use when the license holder's behavioral emergency procedures are unsuccessful in controlling a client's behavior;

(3) the types of behavioral emergency procedures that a staff person may use;

(4) the specific circumstances under which the program may use behavioral emergency procedures; ~~and~~

(5) the staff persons whom the license holder authorizes to implement behavioral emergency procedures.~~;~~ and

(6) the contact information for the local crisis team.

(c) The license holder's behavioral emergency procedures must not include secluding or restraining a client except as allowed under section 245.8261.

(d) Staff persons must not use behavioral emergency procedures to enforce program rules or for the convenience of staff persons. Behavioral emergency procedures must not be part of any client's treatment plan. A staff person may not use behavioral emergency procedures except in response to a client's current behavior that threatens the immediate safety of the client or others.

Sec. 22. Minnesota Statutes 2024, section 245I.03, is amended by adding a subdivision to read:

Subd. 11. **Quality assurance and improvement plan.** (a) At a minimum, a license holder must develop a written quality assurance and improvement plan that includes plans for:

(1) encouraging ongoing consultation among members of the treatment team;

(2) obtaining and evaluating feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measuring and evaluating client outcomes;

(4) reviewing client suicide deaths and suicide attempts;

(5) examining the quality of clinical service delivery to clients; and

(6) self-monitoring of compliance with this chapter.

(b) At least annually, a license holder must review, evaluate, and update the quality assurance and improvement plan. The review must:

(1) include documentation of the actions that the certification holder will take as a result of information obtained from monitoring activities in the plan; and

(2) establish goals for improved service delivery to clients for the next year.

Sec. 23. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 5, is amended to read:

Subd. 5. **Behavioral health practitioner scope of practice.** (a) A behavioral health practitioner under the treatment supervision of a mental health professional or certified rehabilitation specialist may provide an adult client with client education, rehabilitative mental health services, functional assessments, level of care assessments, crisis planning, and treatment plans. A behavioral health practitioner under the treatment supervision of a mental health professional may provide skill-building services ~~to a child client~~, crisis planning, and complete treatment plans for a child client.

(b) A behavioral health practitioner must not provide treatment supervision to other staff persons. A behavioral health practitioner may provide direction to mental health rehabilitation workers and mental health behavioral aides.

(c) A behavioral health practitioner who provides services to clients according to section 256B.0624 may perform crisis assessments and interventions for a client.

Sec. 24. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, is amended to read:

Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment supervision of a mental health professional, a mental health behavioral aide may ~~practice psychosocial skills with~~ provide skill-building services to a child client ~~according to the child's treatment plan and individual behavior plan that a mental health professional, clinical trainee, or behavioral health practitioner has previously taught to the child~~.

Sec. 25. Minnesota Statutes 2024, section 245I.06, subdivision 1, is amended to read:

Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health professional or certified rehabilitation specialist provides treatment supervision to each staff person who provides services to a client and who is not a mental health professional or certified rehabilitation specialist. When providing treatment supervision, a treatment supervisor must follow a staff person's written treatment supervision plan.

(b) Treatment supervision must focus on each client's treatment needs and the ability of the staff person under treatment supervision to provide services to each client, including the following topics related to the staff person's current caseload:

(1) a review and evaluation of the interventions that the staff person delivers to each client;

(2) instruction on alternative strategies if a client is not achieving treatment goals;

(3) a review and evaluation of each client's assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) instruction on the cultural norms or values of the clients and communities that the license holder serves and the impact that a client's culture has on providing treatment;

(5) evaluation of and feedback regarding a direct service staff person's areas of competency; ~~and~~

(6) coaching, teaching, and practicing skills with a staff person~~.~~; and

(7) modeling service practices that respect the client, include the client in planning and implementation of the individual treatment plan, recognize the client's strengths, and coordinate with other involved parties and providers.

(c) A treatment supervisor must provide treatment supervision to a staff person using methods that allow for immediate feedback, including in-person, telephone, and interactive video supervision.

(d) A treatment supervisor's responsibility for a staff person receiving treatment supervision is limited to the services provided by the associated license holder. If a staff person receiving treatment supervision is employed by multiple license holders, each license holder is responsible for providing treatment supervision related to the treatment of the license holder's clients.

Sec. 26. Minnesota Statutes 2024, section 245I.06, subdivision 2, is amended to read:

Subd. 2. **Treatment supervision planning.** (a) A treatment supervisor and the staff person supervised by the treatment supervisor must develop a written treatment supervision plan. The license holder must ensure that a new staff person's treatment supervision plan is completed, approved by the staff person, and implemented by a treatment supervisor and the new staff person within 30 days of the new staff person's first day of employment. The license holder must review and update each staff person's treatment supervision plan annually.

(b) Each staff person's treatment supervision plan must include:

(1) the name and qualifications of the staff person receiving treatment supervision;

(2) the names and licensures of the treatment supervisors who are supervising the staff person;

(3) how frequently the treatment supervisors must provide treatment supervision to the staff person; and

(4) the staff person's authorized scope of practice, including a description of the client ~~population~~ ages that the staff person serves, and a description of the treatment methods and modalities that the staff person may use to provide services to clients.

Sec. 27. Minnesota Statutes 2024, section 245I.07, is amended to read:

245I.07 PERSONNEL FILES.

(a) For each staff person, a license holder must maintain a personnel file that includes:

(1) verification of the staff person's qualifications required for the position including training, education, practicum or internship agreement, licensure, and any other required qualifications;

(2) documentation related to the staff person's background study;

(3) the hiring date of the staff person;

(4) a description of the staff person's job responsibilities with the license holder;

(5) the date that the staff person's specific duties and responsibilities became effective, including the date that the staff person began having direct contact with clients;

(6) documentation of the staff person's training as required by section 245I.05, subdivision 2;

(7) a verification copy of license renewals that the staff person completed during the staff person's employment;

(8) annual job performance evaluations; and

(9) if applicable, the staff person's alleged and substantiated violations of the license holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license holder's response.

(b) The license holder must ensure that all personnel files are readily accessible for the commissioner's review. The license holder is not required to keep personnel files in a single location.

(c) For a license holder under section 245I.17, a personnel file for staff who provide substance use disorder treatment services must include records of training required under section 245G.13, subdivision 2.

Sec. 28. Minnesota Statutes 2024, section 245I.10, is amended by adding a subdivision to read:

Subd. 2a. **Evaluation, treatment authorization, and planning in a certified community behavioral health clinic.** Notwithstanding subdivisions 2 and 7, a license holder under section 245I.17 must meet the requirements for assessments under section 245I.17, subdivisions 11 and 12, and for treatment planning under section 245I.17, subdivision 13. Certified community behavioral health clinic service planning and authorization must comply with the standards in section 245I.17.

Sec. 29. Minnesota Statutes 2024, section 245I.10, subdivision 6, is amended to read:

Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health professional or a clinical trainee may complete a standard diagnostic assessment of a client. A standard diagnostic assessment of a client must include a face-to-face interview with a client and a written evaluation of the client. The assessor must complete a client's standard diagnostic assessment within the client's cultural context. An alcohol and drug counselor may gather and document the information in paragraphs (b) and (c) when completing a comprehensive assessment according to section 245G.05.

(b) When completing a standard diagnostic assessment of a client, the assessor must gather and document information about the client's current life situation, including the following information:

(1) the client's age;

(2) the client's current living situation, including the client's housing status and household members;

(3) the status of the client's basic needs;

(4) the client's education level and employment status;

(5) the client's current medications;

(6) any immediate risks to the client's health and safety, including withdrawal symptoms, medical conditions, and behavioral and emotional symptoms;

(7) the client's perceptions of the client's condition;

(8) the client's description of the client's symptoms, including the reason for the client's referral;

(9) the client's history of mental health and substance use disorder treatment;

(10) cultural influences on the client; and

(11) substance use history, if applicable, including:

(i) amounts and types of substances, frequency and duration, route of administration, periods of abstinence, and circumstances of relapse; and

(ii) the impact to functioning when under the influence of substances, including legal interventions.

(c) If the assessor cannot obtain the information that this paragraph requires without retraumatizing the client or harming the client's willingness to engage in treatment, the

assessor must identify which topics will require further assessment during the course of the client's treatment. The assessor must gather and document information related to the following topics:

(1) the client's relationship with the client's family and other significant personal relationships, including the client's evaluation of the quality of each relationship;

(2) the client's strengths and resources, including the extent and quality of the client's social networks;

(3) important developmental incidents in the client's life;

(4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

(5) the client's history of or exposure to alcohol and drug usage and treatment; and

(6) the client's health history and the client's family health history, including the client's physical, chemical, and mental health history.

(d) When completing a standard diagnostic assessment of a client, an assessor must use a recognized diagnostic framework.

(1) When completing a standard diagnostic assessment of a client who is five years of age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood published by Zero to Three.

(2) When completing a standard diagnostic assessment of a client who is six years of age or older, the assessor must use the current edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

(3) When completing a standard diagnostic assessment of a client who is 12 to 17 years of age, an assessor must use either the CRAFFT Questionnaire or the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

~~(3)~~ (4) When completing a standard diagnostic assessment of a client who is 18 years of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association to screen and assess the client for a substance use disorder.

(e) When completing a standard diagnostic assessment of a client, the assessor must include and document the following components of the assessment:

(1) the client's mental status examination;

(2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources; vulnerabilities; safety needs, including client information that supports the assessor's findings after applying a recognized diagnostic framework from paragraph (d); and any differential diagnosis of the client; and

(3) an explanation of: (i) how the assessor diagnosed the client using the information from the client's interview, assessment, psychological testing, and collateral information about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths; and (v) the client's responsivity factors.

(f) When completing a standard diagnostic assessment of a client, the assessor must consult the client and the client's family about which services that the client and the family prefer to treat the client. ~~The assessor must make referrals for the client as to services required by law.~~

(g) Information from other providers and prior assessments may be used to complete the diagnostic assessment if the source of the information is documented in the diagnostic assessment.

(h) If the client screens positive for a need for substance use disorder treatment services, the assessor must document what actions will be taken to address the client's co-occurring conditions.

(i) The assessor must determine if the client is eligible for targeted case management services according to section 245.462, subdivision 20, or 245.4871, subdivision 6, and refer the client to the county or contracted provider as appropriate.

Sec. 30. Minnesota Statutes 2024, section 245I.10, subdivision 8, is amended to read:

Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's diagnostic assessment or reviewing a client's diagnostic assessment received from a different provider and before providing services to the client beyond those permitted under subdivision 7, the license holder must complete the client's individual treatment plan. The license holder must:

(1) base the client's individual treatment plan on the client's diagnostic assessment and baseline measurements;

(2) for a child client, use a child-centered, family-driven, and culturally appropriate planning process that allows the child's parents and guardians to observe and participate in the child's individual and family treatment services, assessments, and treatment planning;

(3) for an adult client, use a person-centered, culturally appropriate planning process that allows the client's family and other natural supports to observe and participate in the client's treatment services, assessments, and treatment planning;

(4) identify the client's treatment goals, measureable treatment objectives, a schedule for accomplishing the client's treatment goals and objectives, a treatment strategy, and the individuals responsible for providing treatment services and supports to the client. The license holder must have a treatment strategy to engage the client in treatment if the client:

(i) has a history of not engaging in treatment; and

(ii) is ordered by a court to participate in treatment services or to take neuroleptic medications;

(5) identify the participants involved in the client's treatment planning. The client must be a participant in the client's treatment planning. If applicable, the license holder must document the reasons that the license holder did not involve the client's family, case manager, or other natural supports in the client's treatment planning; and

~~(6) review the client's individual treatment plan every 180 days and update the client's individual treatment plan with the client's treatment progress, new treatment objectives and goals or, if the client has not made treatment progress, changes in the license holder's approach to treatment; and~~

~~(7)~~ (6) ensure that the client approves of the client's individual treatment plan unless a court orders the client's treatment plan under chapter 253B.

(b) If the client disagrees with the client's treatment plan, the license holder must document in the client file the reasons why the client does not agree with the treatment plan. If the license holder cannot obtain the client's approval of the treatment plan, a mental health professional must make efforts to obtain approval from a person who is authorized to consent on the client's behalf within 30 days after the client's previous individual treatment plan expired. A license holder may not deny a client service during this time period solely because the license holder could not obtain the client's approval of the client's individual treatment plan. A license holder may continue to bill for the client's otherwise eligible services when the client re-engages in services.

(c) The individual treatment plan must be updated as necessary to reflect the changing needs of the client. The individual treatment plan must provide assistance with accessing necessary crisis services when the license holder is aware of the client's need for crisis services. The license holder must review the client's individual treatment plan every 180 days and update the client's individual treatment plan with the client's treatment progress, new treatment objectives and goals, or, if the client has not made treatment progress, changes in the license holder's approach to treatment.

Sec. 31. **[245I.17] CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC LICENSURE.**

Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "Care coordination" means the activities required to coordinate care across settings and providers for an individual served to ensure seamless transitions across the full spectrum of health services. Care coordination includes:

(1) outreach and engagement;

(2) documenting a plan of care for medical, behavioral health, and social services and supports in the integrated treatment plan;

(3) assisting with obtaining appointments;

(4) confirming appointments are kept;

(5) developing a crisis plan;

(6) tracking medication; and

(7) implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation with primary care practitioners and with mental health clinical care practitioners.

(c) "CCBHC client" means an individual who has participated in a preliminary screening and risk assessment and who has received at least one of the nine required services from a CCBHC.

(d) "Certified community behavioral health clinic" or "CCBHC" means a provider of integrated behavioral health services that is licensed under this section and compliant with federal CCBHC requirements.

(e) "Community needs assessment" means an assessment to identify community needs and determine the community behavioral health clinic's capacity to address the needs of the population being served.

(f) "Designated collaborating organization" means an entity meeting the requirements of subdivision 5 that has a formal agreement with a CCBHC to furnish CCBHC services.

(g) "Federal CCBHC criteria" means the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(h) "Needs assessment" means the community needs assessment described in federal criteria for CCBHC.

(i) "Preliminary screening and risk assessment" means a mandatory screening and risk assessment that is completed at the time of first contact, whether that contact is in person, by telephone, or using other remote communication.

Subd. 2. **Establishment of licensure.** (a) The certified community behavioral health clinic model is an integrated service delivery model that uses evidence-based behavioral health practices to achieve better outcomes for individuals experiencing behavioral health concerns while achieving sustainable rates through cost-based reimbursement for providers and economic efficiencies for payors.

(b) Beginning January 1, 2028, a CCBHC must be licensed under this section and chapter 245A.

(c) A CCBHC must meet the requirements of this section and federal CCBHC criteria. The commissioner may require a CCBHC applicant or license holder to submit documentation of compliance with state licensing requirements and federal CCBHC criteria. When permitted by the Substance Abuse and Mental Health Services Administration, the commissioner may select a transition date on which revisions to the federal CCBHC criteria become required as licensing conditions for CCBHCs.

Subd. 3. **License extension.** (a) The commissioner must extend a compliant license holder's license under this section for 36 months.

(b) The commissioner must complete a licensing review that includes an on-site inspection within six months before the expiration of the CCBHC's current license.

(c) Within 180 days of license expiration, a CCBHC license holder must submit to the commissioner all documentation required by the commissioner under subdivision 2, paragraph (c).

Subd. 4. **Required services and scope of licensure.** Within a declared service area, the CCBHC must be able to offer:

(1) mobile crisis services, directly or through a designated collaborating organization under subdivision 4;

(2) outpatient mental health and substance use disorder treatment services under subdivisions 9 and 10;

(3) screening, diagnosis, and risk assessment under subdivision 11;

(4) person- and family-centered treatment planning;

(5) psychiatric rehabilitation services under subdivision 14;

(6) community-based mental health care for veterans under subdivision 15;

(7) outpatient primary care screening and monitoring under subdivision 16;

(8) peer services under subdivision 17; and

(9) targeted case management under subdivision 18.

Subd. 5. **Designated collaborating organization.** (a) If a CCBHC is unable to provide mobile crisis services, the CCBHC may contract with another entity that is licensed to provide mobile crisis services under section 245I.24 and that meets the requirements of the federal CCBHC criteria as a designated collaborating organization.

(b) The CCBHC must submit a designated collaborating organization arrangement for approval to the commissioner as part of the licensing process.

Subd. 6. **Exemptions to host county approval.** Notwithstanding any other law that requires a county contract or other form of county approval for a service listed in subdivision 4, a CCBHC that meets the requirements of this section may receive the prospective payment under section 256B.0625, subdivision 5m, for that service without a county contract or county approval.

Subd. 7. **Variances.** When the standards listed in this section or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner must consult with stakeholders before granting variances under this provision. For a CCBHC that is licensed but not approved for prospective payment under section 256B.0625, subdivision 5m, the

commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

Subd. 8. **Evidence-based practices.** The commissioner must issue a list of required evidence-based practices to be delivered by CCBHCs and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. When developing the list, the commissioner must consider the adequacy of evidence to support the efficacy of the practice across cultures and ages, the workforce available, and the current availability of the practices in the state. At least 30 days before issuing the initial list or issuing any revisions, the commissioner must provide stakeholders with an opportunity to comment.

Subd. 9. **Outpatient mental health services.** (a) A license holder must provide outpatient mental health services that comply with the federal CCBHC criteria and applicable state standards in this chapter, except as provided in this subdivision.

(b) Completion of an initial or comprehensive evaluation fulfills the requirements to perform a diagnostic assessment in accordance with section 245I.10, subdivisions 2 and 6.

(c) An integrated treatment plan under this section fulfills the requirements to conduct treatment planning in accordance with section 245I.10, subdivisions 7 and 8.

(d) A license holder under this section is exempt from certification as a mental health clinic under section 245I.20.

Subd. 10. **Outpatient substance use disorder treatment.** (a) When a license holder provides substance use disorder treatment services to an individual with a substance use disorder diagnosis, the license holder must comply with the requirements for substance use disorder treatment services in chapter 245G, except as provided in this subdivision.

(b) Completion of a preliminary screening and risk assessment under this section fulfills the requirements to complete an initial services plan under section 245G.04, subdivision 1.

(c) Completion of a comprehensive evaluation under this section fulfills the requirements to administer a comprehensive assessment under section 245G.05.

(d) An integrated treatment plan under this section that contains a six-dimension analysis of the client's needs according to the third edition of ASAM criteria, as defined in section 254B.01, subdivision 2a, fulfills the requirements to provide an individual treatment plan under section 245G.06.

(e) A license holder under this section fulfills the requirement to document personnel files under section 245G.13, subdivision 3, by complying with the requirements of this chapter.

(f) A license holder under this section fulfills the requirement to protect client rights under section 245G.15 by complying with the requirements of section 245I.12.

(g) A license holder under this section fulfills the requirements to respond to behavioral emergencies under section 245G.16 by complying with the requirements of section 245I.03, subdivision 4.

(h) A license holder under this section is exempt from licensure under chapter 245G.

Subd. 11. **Initial triage and risk assessment.** (a) A license holder must have policies and procedures on:

(1) how staff will implement the requirements of this subdivision;

(2) staff positions authorized to complete triage and risk assessments;

(3) documenting the results of the risk screenings; and

(4) ensuring the client is offered timely services according to the federal CCBHC criteria.

(b) A license holder must conduct an initial triage and risk assessment when a new client requests services or is referred to services. A license holder may conduct an initial triage and risk assessment in person, by telephone, or through other remote communication. Based on the acuity of needs as assessed in the initial triage and risk assessment, the client must be categorized as having emergency, urgent, or routine needs.

(c) Based on these categorizations, the license holder must offer services that meet the relevant timelines under the federal CCBHC criteria.

(d) The license holder must provide training that addresses:

(1) when a prospective client requires intervention from qualified staff;

(2) the use of standardized measures that screen for significant risks;

(3) other factors that indicate a client has urgent needs besides the Columbia Suicide Severity Rating Scale or a self-harm screening; and

(4) overdose and substance use disorder risks.

Subd. 12. **Initial and comprehensive evaluation.** (a) A license holder under this section must provide initial and comprehensive evaluations according to this section and federal CCBHC criteria.

(b) An initial evaluation is necessary to authorize the provision of all medically necessary CCBHC services until the completion of a comprehensive evaluation. A comprehensive evaluation is necessary to authorize the provision of all medically necessary CCBHC services on an ongoing basis. A license holder must ensure that each client's comprehensive evaluation reflects the needs and assessments for all services provided.

Subd. 13. **Integrated treatment plan.** (a) A license holder under this section must complete an integrated treatment plan for each client following the client's comprehensive evaluation no later than 60 calendar days after the date of the first request for services.

(b) A license holder must document all required services under subdivision 9 within the integrated treatment plan based on the client's needs.

(c) A license holder must review and update a client's integrated treatment plan as necessary to reflect the changing needs of the client and progress made in treatment. If the client has not made treatment progress, updates to the treatment plan must indicate changes in the license holder's approach to treatment to better meet the needs of the client. A license holder must review and update the integrated treatment plan at least every 180 days or as clinically indicated.

Subd. 14. **Psychiatric rehabilitation services.** (a) For children, a license holder under this section must provide children's therapeutic services and supports according to sections 245I.30 and 245I.31, except that an initial or comprehensive assessment under this section fulfills the requirement to perform a standard diagnostic assessment.

(b) For adults, a license holder under this section must provide adult rehabilitative mental health services according to section 245I.22, except that:

(1) the license holder is exempt from the requirement to perform a level of care assessment under section 245I.22, subdivision 6, paragraph (b); and

(2) an initial or comprehensive assessment under this section fulfills the requirement to perform a standard diagnostic assessment.

Subd. 15. **Community-based care for veterans.** (a) The license holder must provide services according to federal requirements for eligibility and coordination with TRICARE and the United States Department of Veterans Affairs.

(b) The license holder must assign and document a principal behavioral health provider for every veteran receiving services.

Subd. 16. **Primary care screening and monitoring.** To fulfill the requirements for primary care screening, a license holder under this section must have policies and procedures

detailing the screenings to be performed with specific populations at the clinic. The policies and procedures must be approved by the medical director.

Subd. 17. **Peer services.** A license holder must be able to provide peer services as described by federal CCBHC criteria and sections 245G.07, subdivision 2, clause (8), 256B.0615, and 256B.0616.

Subd. 18. **Targeted case management.** (a) A license holder must provide mental health targeted case management as described by federal CCBHC criteria and section 256B.0625, subdivision 20.

(b) An initial or comprehensive evaluation under this section fulfills any requirement to perform a standard diagnostic assessment for targeted case management.

Subd. 19. **Community needs assessment.** (a) The community needs assessment must be a collaborative document that reflects the license holder's or applicant's engagement with current clients, other social and medical services agencies, community groups, underserved populations, and government agencies. The applicant or license holder must document an outreach plan within the community needs assessment to demonstrate how stakeholder feedback was solicited and reflected in the plan.

(b) The applicant or license holder must publicly post a draft community needs assessment on the organization's website for 30 days and submit a summary of public comments and recommendations from the comment period to the commissioner.

(c) In the draft community needs assessment, the applicant or license holder must declare a planned geographic service delivery area in which the CCBHC will be capable of providing all nine required services. An applicant must provide an analysis of how CCBHC status will lead to a significant improvement in the availability and quality of the services. An existing license holder must include analysis of which needs from prior needs assessments have been improved by the operation of the CCBHC. A clinic that has not made and demonstrated substantial progress in addressing the identified needs must specify what changes will occur to address the lack of progress.

(d) The commissioner must provide feedback and technical assistance if the community needs assessment must be revised.

Subd. 20. **Staffing plan.** Based on an accepted community needs assessment, the applicant or license holder must complete a staffing plan. The staffing plan must include analysis of the extent to which identified staffing levels will be capable of meeting the needs identified in the community needs assessment.

Subd. 21. **Data and evaluation.** A provider must submit documentation that establishes the ability of the clinic to complete the required data collection as a CCBHC, as determined by the commissioner. For an applicant that is an existing provider, the commissioner must review and evaluate data submitted related to claims, grants, and other reporting to ensure the data meets reporting requirements.

Subd. 22. **Cost reporting.** A provider must submit a cost report on the forms and in the manner required in section 256B.0625, subdivision 5m.

Sec. 32. **[245I.22] ADULT REHABILITATIVE MENTAL HEALTH SERVICES.**

Subdivision 1. **Generally.** Beginning January 1, 2028, a provider of adult mental health rehabilitative services must be licensed under this section and chapter 245A.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "Adult mental health rehabilitative services" or "ARMHS" has the meaning given in section 245I.02, subdivision 33.

(c) "Basic living skills" means rehabilitative interventions that instruct, assist, and support the client with:

(1) interpersonal communication skills;

(2) community resource utilization and integration skills;

(3) crisis planning;

(4) relapse prevention skills;

(5) health care directives;

(6) budgeting and shopping skills;

(7) healthy lifestyle skills and practices;

(8) cooking and nutrition skills;

(9) transportation skills;

(10) mental illness symptom management skills;

(11) household management skills;

(12) employment-related skills; and

(13) parenting skills.

(d) "Community intervention" means a client's community assisting in the client's rehabilitation, including consultation with relatives, guardians, friends, employers, treatment providers, and other significant individuals. Community intervention is appropriate when directed exclusively to the treatment of the client.

(e) "Medication education services" means services provided individually or in groups that focus on educating the client about mental illness and symptoms, the role and effects of medications in treating symptoms of mental illness, and the side effects of medications. Medication education services must be coordinated with, but must not duplicate, medication management services. Medication education services must be provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(f) "Transition to community living services" means services that maintain continuity of contact between the ARMHS provider and the client and facilitate discharge from a hospital, residential treatment program, board and lodging facility, or nursing home. Transition to community living services must not be used to provide other areas of adult rehabilitative mental health services.

Subd. 3. **Service components.** An ARMHS provider must be capable of providing:

(1) basic living skills;

(2) medication education services;

(3) community intervention; and

(4) transition to community living services.

Subd. 4. **Provider requirements.** An ARMHS license holder must be enrolled with medical assistance and comply with standards in section 256B.0623.

Subd. 5. **Qualifications.** ARMHS must be provided by:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

(3) a clinical trainee qualified under section 245I.04, subdivision 6;

(4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

(5) a mental health certified peer specialist qualified under section 245I.04, subdivision 12; or

(6) a mental health rehabilitation worker qualified under section 245I.04, subdivision 14.

Subd. 6. **Service planning.** (a) An ARMHS provider must complete a written functional assessment according to section 245I.10, subdivision 9, for each client.

(b) When an ARMHS provider completes a written functional assessment, the provider must also complete a level of care assessment, as defined in section 245I.02, subdivision 19, for the client.

Subd. 7. **Group modality.** ARMHS may be provided in group settings if appropriate to each participating client's needs and treatment plan. A group is defined as two to ten clients, at least one of whom is concurrently receiving ARMHS. The service and group must be specified in the client's individual treatment plan.

Sec. 33. **[245I.24] MOBILE CRISIS RESPONSE SERVICES.**

Subdivision 1. **Generally.** (a) Mobile crisis response services provide short-term, face-to-face mental health care in community settings for adults and children experiencing crisis to help individuals maintain safety and return to a baseline level of functioning.

(b) Beginning January 1, 2028, a provider of mobile crisis response services must be licensed under this section and chapter 245A.

Subd. 2. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "Crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or a qualified member of a crisis team, as described in subdivision 5.

(c) "Crisis intervention" means face-to-face, short-term intensive mental health services initiated during a mental health crisis to help an individual cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the individual's baseline level of functioning.

(d) "Crisis screening" means a screening of a client's potential mental health crisis situation under subdivision 6.

(e) "Crisis stabilization services" means individualized mental health services that are designed to restore an individual to the individual's baseline level of functioning. Crisis stabilization services may be provided in the individual's home, the home of a family member or friend of the individual, another community setting, a short-term supervised licensed residential program, or an emergency department. Crisis stabilization services include family psychoeducation.

(f) "Crisis team" means the staff of a provider entity who are supervised and prepared to provide mobile crisis services to a client in a potential mental health crisis situation.

(g) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without the provision of crisis response services, would likely result in significantly reducing the individual's levels of functioning in primary activities of daily living, the individual needing emergency services under section 62Q.55, or the individual being placed in a more restrictive setting, including but not limited to inpatient hospitalization.

(h) "Mobile crisis services" means screening, assessment, intervention, and community-based crisis stabilization services that are provided to an individual client. Mobile crisis services does not include residential crisis stabilization.

Subd. 3. **Eligibility.** (a) An individual is eligible for crisis assessment services when the person has screened positive for a potential mental health crisis during a crisis screening.

(b) An individual is eligible for crisis intervention services and crisis stabilization services when the individual has been assessed during a crisis assessment to be experiencing a mental health crisis.

Subd. 4. **Policies, procedures, and practices specified.** (a) In addition to the policies and procedures required by section 245I.03, the license holder must establish, enforce, and maintain policies and procedures to:

(1) ensure that crisis screenings, crisis assessments, and crisis intervention services are available 24 hours per day, seven days per week;

(2) respond to a call for services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area;

(3) have at least one mental health professional on staff at all times and at least one additional staff member capable of leading a crisis response in the community; and

(4) respond to clients in the community according to the requirements and priorities in subdivision 6.

(b) The license holder must provide the commissioner with information about the number of requests for service, the number of clients that the provider serves face-to-face, and client outcomes at least every six months, in a form and manner prescribed by the commissioner.

(c) The license holder must:

(1) provide support for an individual's family and natural supports by enabling the individual's family and natural supports to observe and participate in the individual's treatment, assessments, and planning services;

(2) implement culturally specific treatment identified in the crisis treatment plan that is meaningful and appropriate, as determined by the individual's culture, beliefs, values, and language;

(3) respond to an individual's changing intervention and care needs, as identified by the individual or a family member; and

(4) have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services are provided.

(d) The license holder must coordinate services with:

(1) county emergency services under section 245.469, community hospitals, ambulance services, transportation services, social services, law enforcement, engagement services, and mental health crisis services through regularly scheduled interagency meetings;

(2) other behavioral health service providers, county mental health authorities, or federally recognized American Indian authorities, and others as necessary, with the consent of the individual or parent or guardian;

(3) detoxification, withdrawal management services, and medical stabilization services as needed; and

(4) the individual's case manager if the individual is receiving case management services.

Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Crisis assessment and intervention services must be provided by:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a clinical trainee qualified under section 245I.04, subdivision 6;

(3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

(4) a mental health certified family peer specialist qualified under section 245I.04, subdivision 12; or

(5) a mental health certified peer specialist qualified under section 245I.04, subdivision 10.

(b) When crisis assessment and intervention services are provided to an individual in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) For providers under this section, the 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce the individual's risk of suicide and self-injurious behavior.

(d) At least six hours of the ongoing training under paragraph (c) must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

(e) Individual providers must be experienced in crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision making under emergency conditions and have knowledge of local services and resources.

Subd. 6. **Crisis screening.** (a) A license holder may use the resources of emergency services under section 245.469 for crisis screening. The crisis screening must gather information, determine whether a mental health crisis situation exists, identify parties involved, and determine an appropriate response.

(b) When conducting a crisis screening, a provider must:

(1) employ evidence-based practices to reduce the individual's risk of suicide and self-injurious behavior;

(2) work with the individual to establish a plan and time frame for responding to the individual's mental health crisis, including responding to the individual's immediate need for support by telephone or text message until the provider can respond to the individual face-to-face;

(3) document significant factors in determining whether the individual is experiencing a mental health crisis, including prior requests for crisis services, an individual's recent presentation at an emergency department, known calls to 911 or law enforcement, or information from third parties with knowledge of an individual's history or current needs;

(4) accept calls from interested third parties and consider the additional needs or potential mental health crises that the third parties may be experiencing;

(5) provide psychoeducation, including reducing access to means of suicide, to relevant third parties including family members or other persons living with the individual; and

(6) consider other available services to determine which service intervention would best address the individual's needs and circumstances.

(c) For the purposes of this section, the following situations indicate a positive screen for a potential mental health crisis:

(1) the individual presents at an emergency department or urgent care setting and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for an individual who is potentially subject to transportation under section 253B.051.

(d) The provider must prioritize providing a face-to-face crisis assessment of the individual, unless a provider documents specific evidence to show why the face-to-face assessment was not possible, including insufficient staffing resources, concerns for staff or individual safety, or other clinical factors.

(e) A provider is not required to have direct contact with the individual to determine that the individual is experiencing a potential mental health crisis. A mobile crisis provider may gather relevant information about the individual from a third party to establish the individual's need for services and potential safety factors.

Subd. 7. **Crisis assessment.** (a) If an individual screens positive for a potential mental health crisis, a crisis assessment must be completed. A crisis assessment must evaluate any immediate needs for which services are needed and, as time permits, the individual's:

(1) current life situation;

(2) health information, including current medications;

(3) sources of stress;

(4) mental health problems and symptoms;

(5) strengths;

(6) cultural considerations;

(7) support network;

(8) vulnerabilities;

(9) current functioning; and

(10) preferences, as communicated directly by the individual or as communicated in a health care directive as described in chapters 145C and 253B, the crisis treatment plan described in subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

(b) A provider must conduct a crisis assessment at the individual's location when appropriate and, when not appropriate, document the reasons.

(c) Whenever possible, the assessor must attempt to include input from the individual, the individual's family, and other natural supports to assess whether a crisis exists.

(d) A crisis assessment must include a determination of:

(1) whether the individual is willing to voluntarily engage in treatment;

(2) whether the individual has an advance directive; and

(3) gathering the individual's information and history from involved family or other natural supports.

(e) If a team determines that the individual does not need an acute level of care, the team must provide services or service coordination if the individual has a co-occurring substance use disorder and is otherwise eligible for services.

(f) If, after completing a crisis assessment, a provider refers the individual to an intensive setting, including an emergency department, inpatient hospitalization, or residential crisis stabilization, one of the crisis team members who completed or conferred about the individual's crisis assessment must immediately contact the referral entity and consult with the staff responsible for triage or intake at the referral entity. During the consultation, the crisis team member must convey key findings or concerns that led to the individual's referral. Following the consultation, the provider must also send written documentation to the referral

entity. The provider must document if the individual or the individual's legal guardian signed releases for health records or if an exception under section 144.293, subdivision 5, exists.

Subd. 8. **Crisis intervention services.** (a) If the crisis assessment determines an individual needs mobile crisis intervention services, the license holder must provide crisis intervention services promptly. As able during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the crisis assessment, crisis treatment plan, and actions taken and needed. At least one of the team members must be providing face-to-face crisis intervention services. If providing crisis intervention services, a clinical trainee or mental health practitioner must seek treatment supervision as required in subdivision 10.

(b) If a provider delivers crisis intervention services while the individual is absent, the provider must document the reason for delivering services while the individual is absent.

(c) The mobile crisis intervention team must develop a crisis treatment plan according to subdivision 11.

(d) The mobile crisis intervention team must document which crisis treatment plan goals and objectives have been met and when no further crisis intervention services are required.

(e) If the individual's mental health crisis is stabilized, but the individual needs a referral to other services, the team must provide referrals to these services. If the individual is unable to follow up on the referral, the team must link the individual to the service and follow up to ensure the individual is receiving the service.

Subd. 9. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity, which must:

(1) develop a crisis treatment plan that meets the criteria in subdivision 11;

(2) complete a vulnerable adult determination in accordance with section 245A.65, subdivision 1a;

(3) deliver crisis stabilization services according to the crisis treatment plan and include face-to-face contact with the individual receiving services by qualified staff for further assessment, help with referrals, updating of the crisis treatment plan, skills training, and collaboration with other service providers in the community;

(4) if the provider delivers crisis stabilization services while the individual is absent, document the reason for delivering services while the individual is absent; and

(5) if the individual's mental health crisis is stabilized and the individual does not have a health care directive or psychiatric declaration, as defined in chapter 145C or section 253B.03, subdivision 6d, offer to work with the individual to develop a directive or declaration.

(b) A staff member providing crisis stabilization services must be:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist qualified under section 245I.04, subdivision 8;

(3) a clinical trainee qualified under section 245I.04, subdivision 6;

(4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

(5) a mental health certified family peer specialist qualified under section 245I.04, subdivision 12;

(6) a mental health certified peer specialist qualified under section 245I.04, subdivision 10; or

(7) a mental health rehabilitation worker qualified under section 245I.04, subdivision 14.

(c) For providers under this section, the 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce an individual's risk of suicide and self-injurious behavior.

(d) For providers who deliver care to children 21 years of age or younger, at least six hours of the ongoing training under this subdivision must be specific to working with families and providing crisis stabilization services to children, including the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

This paragraph does not apply to adult residential crisis stabilization services providers licensed under section 245I.23 or providing services pursuant to section 256B.0624, subdivision 7a.

Subd. 10. **Supervision.** Clinical trainees and mental health practitioners may provide crisis assessment and crisis intervention services if the following treatment supervision requirements are met:

(1) the license holder must accept full responsibility for the services provided;

(2) a mental health professional working for the license holder must be immediately available by telephone or in person for treatment supervision;

(3) a mental health professional must be consulted, in person or by telephone, during the first three hours when a clinical trainee or mental health practitioner provides crisis assessment or crisis intervention services; and

(4) a mental health professional must:

(i) review and approve, as defined in section 245I.02, subdivision 2, the tentative crisis assessment and crisis treatment plan within 24 hours of first providing services to the individual, notwithstanding section 245I.08, subdivision 3; and

(ii) document the consultation required in clause (3).

Subd. 11. **Crisis treatment plan.** (a) Within 24 hours of an individual's admission, the license holder must complete the individual's crisis treatment plan. The license holder must:

(1) base the individual's crisis treatment plan on the individual's crisis assessment;

(2) consider crisis assistance strategies that have been effective for the individual in the past;

(3) for a child, use a child-centered, family-driven, and culturally appropriate planning process that allows the child's parents and guardians to observe or participate in the child's individual and family treatment services, assessment, and treatment planning;

(4) for an adult, use a person-centered, culturally appropriate planning process that allows the individual's family and other natural supports to observe or participate in treatment services, assessment, and treatment planning;

(5) identify the participants involved in the individual's treatment planning. The individual must be a participant if possible;

(6) identify the individual's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the person engage in treatment;

(7) include documentation of referral to and scheduling of services, including specific providers where applicable;

(8) ensure that the individual or the individual's legal guardian approves under section 245I.02, subdivision 2, of the individual's crisis treatment plan unless a court orders the individual's treatment plan under chapter 253B. If the individual or the individual's legal guardian disagrees with the crisis treatment plan, the license holder must document in the client file the reasons why the individual disagrees with the crisis treatment plan; and

(9) ensure that a treatment supervisor approves, as defined in section 245I.02, subdivision 2, of the individual's treatment plan within 24 hours of the individual's admission if a mental health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section 245I.08, subdivision 3.

(b) The provider entity must provide the individual and the individual's legal guardian with a copy of the crisis treatment plan.

Subd. 12. **Application requirements.** In a licensing application submitted under this section and section 245A.04, the applicant must demonstrate that the applicant is:

(1) enrolled as a medical assistance provider; and

(2) in compliance with the provider type requirements under section 256B.0624, subdivision 4, as determined by the commissioner.

Sec. 34. **[245I.30] CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

Subdivision 1. **Generally.** (a) "Children's therapeutic services and supports" means a flexible package of community-based mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness. Interventions are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan. Children's therapeutic services and supports include development and rehabilitative services that support a child's developmental treatment needs.

(b) Beginning January 1, 2028, a provider of children's therapeutic services and supports must be licensed under this section and chapter 245A.

Subd. 2. **Service components.** (a) A children's therapeutic services and supports license holder must be capable of providing:

(1) individual and family psychotherapy, psychotherapy for crises, and group psychotherapy;

(2) individual, family, or group skills training; and

(3) crisis planning.

(b) Crisis planning that meets the standards in section 245.4871, subdivision 9a, must be offered to each client's family.

Subd. 3. **Provider requirements.** A children's therapeutic services and supports license holder must be enrolled with medical assistance and comply with the requirements in section 256B.0943.

Subd. 4. **Qualifications of provider staff.** Children's therapeutic services and supports must be provided by:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a clinical trainee qualified under section 245I.04, subdivision 6;

(3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

(4) a mental health certified family peer specialist qualified under section 245I.04, subdivision 12; or

(5) a mental health behavioral aide qualified under section 245I.04, subdivision 16.

Subd. 5. **Group modality.** Group skills training may be provided to multiple clients who, because of the nature of the clients' emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting. A group must consist of two to ten clients, at least one of whom is a client and is concurrently receiving a service under this section. The service and group must be specified in the client's individual treatment plan.

Sec. 35. **[245I.31] CHILDREN'S DAY TREATMENT.**

Subdivision 1. **Generally.** (a) For the purposes of this section, "children's day treatment program" means a site-based structured mental health program consisting of psychotherapy and individual or group skills training provided by a team under the treatment supervision of a mental health professional.

(b) A children's day treatment program must be licensed for a specific location of operation and must not be part of inpatient or residential treatment services.

(c) A children's day treatment program must stabilize a client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community.

(d) Beginning January 1, 2028, a provider of children's day services must be licensed under this section and chapter 245A.

Subd. 2. **Service components.** A children's day treatment program must be capable of providing the services in section 245I.30, subdivision 2.

Subd. 3. **Provider requirements.** A children's day treatment license holder must:

(1) be enrolled as a provider with medical assistance;

(2) maintain a policy regarding the use of restrictive procedures and meet the requirements of section 245.8261;

(3) maintain a policy on medications in accordance with section 245I.11, subdivision 6; and

(4) meet group modality requirements in section 245I.30, subdivision 5.

Subd. 4. **Qualifications of provider staff.** Children's day treatment services must be provided by:

(1) a mental health professional qualified under section 245I.04, subdivision 2;

(2) a clinical trainee qualified under section 245I.04, subdivision 6; or

(3) a behavioral health practitioner qualified under section 245I.04, subdivision 4.

Sec. 36. Minnesota Statutes 2024, section 256B.0623, subdivision 1, is amended to read:

Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically necessary adult rehabilitative mental health services when the services are provided by an entity ~~meeting the standards in this section~~ licensed under section 245I.24. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 37. Minnesota Statutes 2024, section 256B.0623, subdivision 3, is amended to read:

Subd. 3. **Eligibility.** An eligible recipient is an individual who:

(1) is age 18 or older;

(2) is diagnosed with a medical condition, such as mental illness or traumatic brain injury, for which adult rehabilitative mental health services are needed;

(3) has substantial disability and functional impairment in three or more of the areas listed in section 245I.10, subdivision 9, paragraph (a), clause (4), so that self-sufficiency is markedly reduced; and

(4) has had a recent standard diagnostic assessment pursuant to section 245I.10, subdivision 6, by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 38. Minnesota Statutes 2024, section 256B.0623, subdivision 12, is amended to read:

Subd. 12. **Additional requirements.** ~~(a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.~~

~~(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community.~~ (a) Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or section 245I.23, or an acute care hospital.

~~(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and individual treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's individual treatment plan.~~ (b) No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

~~(d)~~ (c) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

~~(e) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas including: interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom management skills, household management skills, employment-related skills, parenting skills, and transition to community living services.~~

~~(f) Community intervention, including consultation with relatives, guardians, friends, employers, treatment providers, and other significant individuals, is appropriate when directed exclusively to the treatment of the client.~~

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 39. Minnesota Statutes 2024, section 256B.0624, subdivision 1, is amended to read:

Subdivision 1. **Scope.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically necessary crisis response services when the services are provided according to the standards in ~~this~~ section 245I.24.

(b) ~~Subject to federal approval,~~ Medical assistance covers medically necessary residential crisis stabilization for adults when the services are provided by an entity licensed under and meeting the standards in section 245I.23 or an entity with an adult foster care license meeting the standards in ~~this section~~ subdivision 7a.

(c) The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner using instruments and protocols approved by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 40. Minnesota Statutes 2024, section 256B.0624, subdivision 4, is amended to read:

Subd. 4. **Provider entity standards.** (a) A mobile crisis provider must be:

(1) a county board operated entity;

(2) an Indian health services facility or facility owned and operated by a tribe or Tribal organization operating under United States Code, title 325, section 450f; or

(3) a provider entity that is under contract with the county board in the county where the potential crisis or emergency is occurring. To provide services under this section, the provider entity must directly provide the services; or if services are subcontracted, the provider entity must maintain responsibility for services and billing.

~~(b) A mobile crisis provider must meet the following standards:~~

~~(1) ensure that crisis screenings, crisis assessments, and crisis intervention services are available to a recipient 24 hours a day, seven days a week;~~

~~(2) be able to respond to a call for services in a designated service area or according to a written agreement with the local mental health authority for an adjacent area;~~

~~(3) have at least one mental health professional on staff at all times and at least one additional staff member capable of leading a crisis response in the community; and~~

~~(4) provide the commissioner with information about the number of requests for service, the number of people that the provider serves face-to-face, outcomes, and the protocols that the provider uses when deciding when to respond in the community.~~

~~(c) A provider entity that provides crisis stabilization services in a residential setting under subdivision 7 is not required to meet the requirements of paragraphs (a) and (b), but must meet all other requirements of this subdivision.~~

~~(d) A crisis services provider must have the capacity to meet and carry out the standards in section 245I.011, subdivision 5, and the following standards:~~

~~(1) ensures that staff persons provide support for a recipient's family and natural supports, by enabling the recipient's family and natural supports to observe and participate in the recipient's treatment, assessments, and planning services;~~

~~(2) has adequate administrative ability to ensure availability of services;~~

~~(3) is able to ensure that staff providing these services are skilled in the delivery of mental health crisis response services to recipients;~~

~~(4) is able to ensure that staff are implementing culturally specific treatment identified in the crisis treatment plan that is meaningful and appropriate as determined by the recipient's culture, beliefs, values, and language;~~

~~(5) is able to ensure enough flexibility to respond to the changing intervention and care needs of a recipient as identified by the recipient or family member during the service partnership between the recipient and providers;~~

~~(6) is able to ensure that staff have the communication tools and procedures to communicate and consult promptly about crisis assessment and interventions as services occur;~~

~~(7) is able to coordinate these services with county emergency services, community hospitals, ambulance, transportation services, social services, law enforcement, engagement services, and mental health crisis services through regularly scheduled interagency meetings;~~

~~(8) is able to ensure that services are coordinated with other behavioral health service providers, county mental health authorities, or federally recognized American Indian authorities and others as necessary, with the consent of the recipient or parent or guardian. Services must also be coordinated with the recipient's case manager if the recipient is receiving case management services;~~

~~(9) is able to ensure that crisis intervention services are provided in a manner consistent with sections 245.461 to 245.486 and 245.487 to 245.4879;~~

~~(10) is able to coordinate detoxification services for the recipient according to Minnesota Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;~~

~~(11) is able to establish and maintain a quality assurance and evaluation plan to evaluate the outcomes of services and recipient satisfaction; and~~

~~(12) is an enrolled medical assistance provider.~~

(b) A mobile crisis provider must ensure services are provided consistent with section 245.469, subdivisions 1 and 2.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 41. Minnesota Statutes 2024, section 256B.0624, is amended by adding a subdivision to read:

Subd. 7a. **Residential crisis stabilization services in adult foster care settings.** (a) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization, the residential setting staff must include, for at least eight hours per day, at least one mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner.

(b) The commissioner must establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider must not exceed the rate charged by that provider for the same service to other payers. Payment must not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner must set rates prospectively for the annual rate period. The commissioner must require providers to submit annual cost reports on a uniform cost reporting form and use submitted cost reports to inform the rate-setting process. The commissioner must recalculate the statewide per diem every year.

(c) A provider under this subdivision must follow the requirements under section 245I.24, subdivisions 4, paragraphs (c) and (d), and 9.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 42. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of section ~~245.735, subdivision 3~~ 245I.17.

(b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section ~~245.735, subdivision 3, paragraph (a), clauses (6) and (7)~~ 245I.17, subdivision 4; and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section ~~245.735, subdivision 3, paragraph (a), clause (6)~~ 245I.17, subdivision 4, is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly ~~certified~~ licensed CCBHCs under section ~~245.735, subdivision 3~~ 245I.17, shall be established by the commissioner using a provider-specific rate based on the newly ~~certified~~ licensed CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change in the scope of services. For CCBHCs certified after September 30, 2020, and before January 1, 2021, the commissioner shall rebase rates according to this clause for services provided on or after January 1, 2024;

(5) the commissioner shall provide for a 60-day appeals process after notice of the results of the rebasing;

(6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal Medicaid rate is not eligible for the CCBHC rate methodology;

(7) payments for CCBHC services to individuals enrolled in managed care shall be coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall complete the phase-out of CCBHC wrap payments within 60 days of the implementation of the CCBHC daily bundled rate system in the Medicaid Management Information System (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments due made payable to CCBHCs no later than 18 months thereafter;

(8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each provider-specific rate by the Medicare Economic Index for primary care services. This update shall occur each year in between rebasing periods determined by the commissioner in accordance with clause (4). CCBHCs must provide data on costs and visits to the state annually using the CCBHC cost report established by the commissioner; and

(9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of services when such changes are expected to result in an adjustment to the CCBHC payment rate by 2.5 percent or more. The CCBHC must provide the commissioner with information

regarding the changes in the scope of services, including the estimated cost of providing the new or modified services and any projected increase or decrease in the number of visits resulting from the change. Estimated costs are subject to review by the commissioner. Rate adjustments for changes in scope shall occur no more than once per year in between rebasing periods per CCBHC and are effective on the date of the annual CCBHC rate update.

(d) Managed care plans and county-based purchasing plans shall reimburse CCBHC providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of this requirement on the rate of access to the services delivered by CCBHC providers. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this provision. This paragraph expires if federal approval is not received for this paragraph at any time.

(e) The commissioner shall implement a quality incentive payment program for CCBHCs that meets the following requirements:

(1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric thresholds for performance metrics established by the commissioner, in addition to payments for which the CCBHC is eligible under the CCBHC daily bundled rate system described in paragraph (c);

(2) a CCBHC must be ~~certified~~ licensed and enrolled as a CCBHC for the entire measurement year to be eligible for incentive payments;

(3) each CCBHC shall receive written notice of the criteria that must be met in order to receive quality incentive payments at least 90 days prior to the measurement year; and

(4) a CCBHC must provide the commissioner with data needed to determine incentive payment eligibility within six months following the measurement year. The commissioner shall notify CCBHC providers of their performance on the required measures and the incentive payment amount within 12 months following the measurement year.

(f) All claims to managed care plans for CCBHC services as provided under this section shall be submitted directly to, and paid by, the commissioner on the dates specified no later than January 1 of the following calendar year, if:

(1) one or more managed care plans does not comply with the federal requirement for payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42, section 447.45(b), and the managed care plan does not resolve the payment issue within 30 days of noncompliance; and

(2) the total amount of clean claims not paid in accordance with federal requirements by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims eligible for payment by managed care plans.

If the conditions in this paragraph are met between January 1 and June 30 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on January 1 of the following year. If the conditions in this paragraph are met between July 1 and December 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning on July 1 of the following year.

(g) Peer services provided by a CCBHC ~~certified~~ licensed under section ~~245.735~~ 245I.17 are a covered service under medical assistance when a licensed mental health professional or alcohol and drug counselor determines that peer services are medically necessary. Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph (b), clause (2).

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 43. Minnesota Statutes 2024, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports when the services are provided by an eligible provider entity ~~certified under and meeting the standards in this section~~ licensed under section 245I.30 or children's day treatment services licensed under section 245I.31. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) The covered service components of children's therapeutic services and supports are:

~~(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;~~

~~(2) individual, family, or group skills training provided by a mental health professional, clinical trainee, or mental health practitioner;~~

~~(3) crisis planning;~~

~~(4) mental health behavioral aide services;~~

(1) the services described in section 245I.30, subdivision 2, provided by providers licensed under section 245I.30 or 245I.31;

(2) administration of standardized measures;

~~(5)~~ (3) direction of a mental health behavioral aide; and

~~(6)~~ (4) mental health service plan development~~; and~~.

~~(7) children's day treatment.~~

(c) In delivering services under this section, a licensed provider entity must ensure that psychotherapy to address a child's underlying mental health disorder is documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive the psychotherapy or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record.

(d) Medical assistance covers service plan development before completion of a child's individual treatment plan. Service plan development consists of development, review, and revision of the individual treatment plan by face-to-face or electronic communication, including time spent gathering client history from other key figures or providers. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Service plan development is covered only if a treatment plan is completed or for work already completed at the time the client voluntarily chooses to disengage with services for the child. If it is determined upon review that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

(e) Medical assistance covers time spent administering and reporting standardized measures approved by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 44. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a clinical trainee that is performed within one year before the initial start of service and updated as required under section 245I.10, subdivision 2. The standard diagnostic assessment must:

(1) determine whether ~~a child under age 18 has a diagnosis of mental illness or, if the person is between the ages of 18 and 21, whether~~ the person has a mental illness; and

(2) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals~~; and~~.

~~(3) be used in the development of the individual treatment plan.~~

(b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

~~(c) Children's therapeutic services and supports include development and rehabilitative services that support a child's developmental treatment needs.~~

Sec. 45. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** (a) The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) treatment by multiple providers within the same agency at the same clock time, unless one service is delivered to the child and the other service is delivered to the child's family or treatment team without the child present;

(3) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(5) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

(ii) a social or educational service that does not have or cannot reasonably be expected to have a therapeutic outcome related to the client's mental illness;

(iii) prevention or education programs provided to the community; and

(iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

(b) Time spent on administrative tasks before and after providing direct services, including scheduling or maintaining clinical records, is included in CTSS payments and may not be separately billed as additional clock hours of service.

Sec. 46. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended to read:

Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency responsible for investigating allegations of maltreatment in child foster care, family child care, legally nonlicensed child care, and reports involving children served by an unlicensed personal care provider organization under section 256B.0659. Copies of findings related to personal care provider organizations under section 256B.0659 must be forwarded to the Department of Human Services provider enrollment.

(b) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment in juvenile correctional facilities listed under section 241.021 located in the local welfare agency's county and in facilities licensed or certified under chapters 245A and 245D.

(c) The Department of Health is the agency responsible for screening and investigating allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43 to 144A.482 or chapter 144H.

(d) The Department of Education is the agency responsible for screening and investigating allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11, and 13, and chapter 124E. The Department of Education's responsibility to screen and investigate includes allegations of maltreatment involving students 18 through 21 years of age, including students receiving special education services, up to and including graduation and the issuance of a secondary or high school diploma.

(e) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors in an EIDBI agency operating under sections 245A.142 and 256B.0949.

(f) A health or corrections agency receiving a report may request the local welfare agency to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

(g) The Department of Children, Youth, and Families is the agency responsible for screening and investigating allegations of maltreatment in facilities or programs not listed in paragraph (a) that are licensed or certified under chapters 142B and 142C.

(h) The Department of Human Services is the agency responsible for screening and investigating allegations of maltreatment of minors for mobile crisis response services and children's therapeutic services and supports programs licensed under chapter 245I.

Sec. 47. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended to read:

Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary administrative agency responsible for investigating reports made under section 626.557.

(a) The Department of Health is the lead investigative agency for facilities or services licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding care homes, hospice providers, residential facilities that are also federally certified as intermediate care facilities that serve people with developmental disabilities, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Health for the care of vulnerable adults. "Home care provider" has the meaning provided in section 144A.43, subdivision 4, and applies when care or services are delivered in the vulnerable adult's home.

(b) The Department of Human Services is the lead investigative agency for facilities or services licensed or required to be licensed as adult day care, adult foster care, community residential settings, programs for people with disabilities, EIDBI agencies, family adult day services, mental health programs licensed under chapter 245I, mental health clinics, substance

use disorder programs, the Minnesota Sex Offender Program, or any other facility or service not listed in this subdivision that is licensed or required to be licensed by the Department of Human Services. The Department of Human Services is also the lead investigative agency for unlicensed EIDBI agencies under section 256B.0949. The Department of Human Services is the lead investigative agency for adult rehabilitative mental health services under section 245I.22, mobile crisis response services under section 245I.24, and certified community behavioral health clinics under section 245I.17.

(c) The county social service agency or its designee is the lead investigative agency for all other reports, including but not limited to reports involving vulnerable adults receiving services from a personal care provider organization under section 256B.0659.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 48. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245.735, subdivisions 5 and 6, as Minnesota Statutes, section 245I.17, subdivisions 23 and 24.

Sec. 49. **REPEALER.**

(a) Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e, 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, and 8; 245C.03, subdivision 7; 245I.20, subdivision 9; 245I.23, subdivision 23; 256B.0623, subdivisions 2, 4, 5, 6, and 9; 256B.0624, subdivisions 2, 3, 4a, 5, 6, 6a, 6b, 7, 8, 9, and 11; and 256B.0943, subdivisions 4, 5, 5a, 6, 7, and 11, are repealed.

(b) Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3 and 4d; and 256B.0943, subdivisions 1 and 9, are repealed.

EFFECTIVE DATE. This section is effective January 1, 2028.

ARTICLE 6
AGING AND DISABILITY SERVICES

Section 1. Minnesota Statutes 2024, section 245D.12, is amended to read:

245D.12 INTEGRATED COMMUNITY SUPPORTS~~; SETTING CAPACITY REPORT~~.

Subdivision 1. **Setting capacity report.** (a) The license holder providing integrated community support, as defined in section 245D.03, subdivision 1, paragraph (c), clause (8), must submit a setting capacity report to the commissioner to ensure the identified location

of service delivery meets the criteria of the home and community-based service requirements as specified in section 256B.492.

(b) The license holder shall provide the setting capacity report on the forms and in the manner prescribed by the commissioner. The report must include:

(1) the address of the multifamily housing building where the license holder delivers integrated community supports and owns, leases, or has a direct or indirect financial relationship with the property owner;

(2) the total number of living units in the multifamily housing building described in clause (1) where integrated community supports are delivered;

(3) the total number of living units in the multifamily housing building described in clause (1), including the living units identified in clause (2);

(4) the total number of people who could reside in the living units in the multifamily housing building described in clause (2) and receive integrated community supports; and

(5) the percentage of living units that are controlled by the license holder in the multifamily housing building by dividing clause (2) by clause (3).

(c) Only one license holder may deliver integrated community supports at the address of the multifamily housing building.

Subd. 2. **Licensure moratorium.** (a) Except as permitted in this subdivision, the commissioner must not issue an initial license under this chapter authorizing integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause (8), and must not approve a license change adding integrated community supports to an existing license under this chapter.

(b) The commissioner may approve an exception to the moratorium only when the applicant or licensee meets all requirements under subdivision 1, the request is not superseded by temporary moratoriums under section 245A.03, subdivision 7a, and the applicant submits documentation demonstrating compliance with:

(1) federal and state home and community-based services requirements for provider-controlled settings;

(2) the prohibition on the use of Medicaid money for room and board under United States Code, title 42, section 1396n(c); and

(3) all licensing requirements applicable to integrated community supports under this chapter.

(c) In determining whether to approve an exception, the commissioner must consider statewide and regional capacity for integrated community supports based on needs determination processes under section 245A.03, subdivision 7, paragraph (e).

(d) A determination under this subdivision is final and not subject to appeal.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 2. Minnesota Statutes 2024, section 256B.0623, is amended by adding a subdivision to read:

Subd. 15. **Billing limits.** The maximum billable units for adult rehabilitation mental health services under this section without authorization from the commissioner are:

(1) four hours per week per recipient combined total of H2017, H2017 HM, and H2017 HQ;

(2) 18 hours per month per recipient combined total of H2017, H2017 HM, and H2017 HQ; or

(3) 200 hours per year per recipient combined total of H2017, H2017 HM, and H2017 HQ.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 3. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 17, is amended to read:

Subd. 17. **Transportation costs.** (a) "Nonemergency medical transportation service" means motor vehicle transportation provided by a public or private person that serves Minnesota health care program beneficiaries who do not require emergency ambulance service, as defined in section 144E.001, subdivision 3, to obtain covered medical services.

(b) For purposes of this subdivision, "rural urban commuting area" or "RUCA" means a census-tract based classification system under which a geographical area is determined to be urban, rural, or super rural. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(c) Medical assistance covers medical transportation costs incurred solely for obtaining emergency medical care or transportation costs incurred by eligible persons in obtaining emergency or nonemergency medical care when paid directly to an ambulance company, nonemergency medical transportation company, or other recognized providers of transportation services. Medical transportation must be provided by:

(1) nonemergency medical transportation providers who meet the requirements of this subdivision;

(2) ambulances, as defined in section 144E.001, subdivision 2;

(3) taxicabs that meet the requirements of this subdivision;

(4) public transportation, within the meaning of "public transportation" as defined in section 174.22, subdivision 7; or

(5) not-for-hire vehicles, including volunteer drivers, as defined in section 65B.472, subdivision 1, paragraph (p).

(d) Medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph. This paragraph expires upon the effective date of paragraph (e).

(e) Effective January 1, 2027, or upon federal approval, whichever is later, medical assistance covers nonemergency medical transportation provided by nonemergency medical transportation providers enrolled in the Minnesota health care programs. All nonemergency medical transportation providers must comply with the operating standards for special transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the commissioner and reported on the claim as the individual who provided the service. All nonemergency medical transportation providers shall bill for nonemergency medical transportation services in accordance with Minnesota health care programs criteria and comply with the requirements of section 256B.073. Publicly operated transit systems, volunteers, and not-for-hire vehicles are exempt from the requirements outlined in this paragraph.

~~(e)~~ (f) An organization may be terminated, denied, or suspended from enrollment if:

(1) the provider has not initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3); or

(2) the provider has initiated background studies on the individuals specified in section 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

(i) the commissioner has sent the provider a notice that the individual has been disqualified under section 245C.14; and

(ii) the individual has not received a disqualification set-aside specific to the special transportation services provider under sections 245C.22 and 245C.23.

~~(f)~~ (g) The administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care programs beneficiaries to obtain covered medical services;

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode; and

(4) by July 1, 2016, in accordance with subdivision 18e, utilize a web-based single administrative structure assessment tool that meets the technical requirements established by the commissioner, reconciles trip information with claims being submitted by providers, and ensures prompt payment for nonemergency medical transportation services. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(g)~~ (h) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid medical assistance, the administrative agency of nonemergency medical transportation must:

(1) adhere to the policies defined by the commissioner;

(2) pay nonemergency medical transportation providers for services provided to Minnesota health care program beneficiaries to obtain covered medical services; and

(3) provide data monthly to the commissioner on appeals, complaints, no-shows, canceled trips, and number of trips by mode.

~~(h)~~ (i) Until the commissioner implements the single administrative structure and delivery system under subdivision 18e, clients shall obtain their level-of-service certificate from the commissioner or an entity approved by the commissioner that does not dispatch rides for clients using modes of transportation under paragraph ~~(n)~~ (o), clauses (4), (5), (6), and (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(i)~~ (j) The commissioner may use an order by the recipient's attending physician, advanced practice registered nurse, physician assistant, or a medical or mental health professional to certify that the recipient requires nonemergency medical transportation services. Nonemergency medical transportation providers shall perform driver-assisted services for eligible individuals, when appropriate. Driver-assisted service includes passenger pickup at and return to the individual's residence or place of business, assistance with admittance of the individual to the medical facility, and assistance in passenger securement or in securing of wheelchairs, child seats, or stretchers in the vehicle.

~~(j)~~ (k) Nonemergency medical transportation providers must take clients to the health care provider using the most direct route, and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the local agency. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(k)~~ (l) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, nonemergency medical transportation providers must take clients to the health care provider using the most direct route and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the administrator.

~~(l)~~ (m) Nonemergency medical transportation providers may not bill for separate base rates for the continuation of a trip beyond the original destination. Nonemergency medical transportation providers must maintain trip logs, which include pickup and drop-off times, signed by the medical provider or client, whichever is deemed most appropriate, attesting to mileage traveled to obtain covered medical services. Clients requesting client mileage reimbursement must sign the trip log attesting mileage traveled to obtain covered medical services.

~~(m)~~ (n) The administrative agency shall use the level of service process established by the commissioner to determine the client's most appropriate mode of transportation. If public transit or a certified transportation provider is not available to provide the appropriate service mode for the client, the client may receive a onetime service upgrade.

~~(n)~~ (o) The covered modes of transportation are:

(1) client reimbursement, which includes client mileage reimbursement provided to clients who have their own transportation, or to family or an acquaintance who provides transportation to the client;

(2) volunteer transport, which includes transportation by volunteers using their own vehicle;

(3) unassisted transport, which includes transportation provided to a client by a taxicab or public transit. If a taxicab or public transit is not available, the client can receive transportation from another nonemergency medical transportation provider;

(4) assisted transport, which includes transport provided to clients who require assistance by a nonemergency medical transportation provider;

(5) lift-equipped/ramp transport, which includes transport provided to a client who is dependent on a device and requires a nonemergency medical transportation provider with a vehicle containing a lift or ramp;

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

(7) stretcher transport, which includes transport for a client in a prone or supine position and requires a nonemergency medical transportation provider with a vehicle that can transport a client in a prone or supine position.

~~(o)~~ (p) The local agency shall be the single administrative agency and shall administer and reimburse for modes defined in paragraph ~~(n)~~ (o) according to paragraphs ~~(r)~~ (s) to ~~(t)~~ (u) when the commissioner has developed, made available, and funded the web-based single administrative structure, assessment tool, and level of need assessment under subdivision 18e. The local agency's financial obligation is limited to funds provided by the state or federal government. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(p)~~ (q) The commissioner shall:

(1) verify that the mode and use of nonemergency medical transportation is appropriate;

(2) verify that the client is going to an approved medical appointment; and

(3) investigate all complaints and appeals.

~~(q)~~ (r) The administrative agency shall pay for the services provided in this subdivision and seek reimbursement from the commissioner, if appropriate. As vendors of medical care, local agencies are subject to the provisions in section 256B.041, the sanctions and monetary

recovery actions in section 256B.064, and Minnesota Rules, parts 9505.2160 to 9505.2245. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(r)~~ (s) Payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle used to provide the service. The medical assistance reimbursement rates for nonemergency medical transportation services that are payable by or on behalf of the commissioner for nonemergency medical transportation services are:

(1) $0.22 per mile for client reimbursement;

(2) up to 100 percent of the Internal Revenue Service business deduction rate for volunteer transport;

(3) equivalent to the standard fare for unassisted transport when provided by public transit, and $12.10 for the base rate and $1.43 per mile when provided by a nonemergency medical transportation provider;

(4) $14.30 for the base rate and $1.43 per mile for assisted transport;

(5) $19.80 for the base rate and $1.70 per mile for lift-equipped/ramp transport;

(6) $75 for the base rate and $2.40 per mile for protected transport; and

(7) $60 for the base rate and $2.40 per mile for stretcher transport, and $9 per trip for an additional attendant if deemed medically necessary. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(s)~~ (t) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, payments for nonemergency medical transportation must be paid based on the client's assessed mode under paragraph ~~(m)~~ (n), not the type of vehicle used to provide the service.

~~(t)~~ (u) The base rate for nonemergency medical transportation services in areas defined under RUCA to be super rural is equal to 111.3 percent of the respective base rate in paragraph ~~(r)~~ (s), clauses (1) to (7). The mileage rate for nonemergency medical transportation services in areas defined under RUCA to be rural or super rural areas is:

(1) for a trip equal to 17 miles or less, equal to 125 percent of the respective mileage rate in paragraph ~~(r)~~ (s), clauses (1) to (7); and

(2) for a trip between 18 and 50 miles, equal to 112.5 percent of the respective mileage rate in paragraph ~~(r)~~ (s), clauses (1) to (7). This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(u)~~ (v) For purposes of reimbursement rates for nonemergency medical transportation services under paragraphs ~~(r)~~ (s) to ~~(t)~~ (u), the zip code of the recipient's place of residence shall determine whether the urban, rural, or super rural reimbursement rate applies. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

~~(v)~~ (w) The commissioner, when determining reimbursement rates for nonemergency medical transportation, shall exempt all modes of transportation listed under paragraph ~~(n)~~ (o) from Minnesota Rules, part 9505.0445, item R, subitem (2).

~~(w)~~ (x) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph ~~(r)~~ (s) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. Minnesota Statutes 2024, section 256B.0625, subdivision 17b, is amended to read:

Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency medical transportation providers must document each occurrence of a service provided to a recipient according to this subdivision. Providers must maintain records sufficient to distinguish individual trips with specific vehicles and drivers. The documentation may be collected and maintained using electronic systems or software or in paper form but must be made available and produced upon request. Program funds paid for transportation that is not documented according to this subdivision may be subject to recovery by the commissioner pursuant to section 256B.064.

(b) A nonemergency medical transportation provider must compile transportation trip records that are written in English and legible according to the standard of a reasonable person and that include each of the following elements:

(1) the recipient's name;

(2) the date or dates the service is provided, if different than the date the entry was made;

(3) either the printed name of the driver sufficient to distinguish the driver of service or the driver's provider number;

(4) the date and the signature of the driver attesting that the record accurately represents the services provided and the actual miles driven, and acknowledging that misreporting information that results in ineligible or excessive payments may result in civil or criminal action;

(5) the date and the signature of the recipient or authorized party attesting that transportation services were provided as indicated on the transportation trip record, or the signature of the medical services provider certifying that the recipient was transported to the medical services provider destination. In the event that both the medical services provider and the recipient or authorized party refuse or are unable to provide signatures, the driver must document on the transportation trip record that signatures were requested and not provided;

(6) the address, or the description if the address is not available, of both the origin and destination, and the mileage for the most direct route from the origin to the destination;

(7) the name or number of the mode of transportation in which the service is provided;

(8) the license plate number of the vehicle used to transport the recipient;

(9) the time of the recipient pickup;

(10) the time of the recipient drop-off;

(11) the odometer reading of the vehicle used to transport the recipient taken at the time of pickup;

(12) the odometer reading of the vehicle used to transport the recipient taken at the time of drop-off;

(13) the name of the extra attendant when an extra attendant is used to provide special transportation service; and

(14) the documentation indicating the method that was used to determine the most direct route.

(c) In determining whether the commissioner will seek recovery, the documentation requirements in this section apply retroactively to audit findings beginning January 1, 2020, and to all audit findings thereafter.

(d) Effective January 1, 2027, or upon federal approval, whichever is later, records that comply with section 256B.073 may be used to meet the requirements of this subdivision if all required elements are included in the record.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 5. Minnesota Statutes 2024, section 256B.073, subdivision 1, is amended to read:

Subdivision 1. **Documentation; establishment and operation.** The commissioner of human services shall establish ~~implementation requirements and standards for~~ and maintain the requirements and standards for the ongoing operation of electronic visit verification to comply with the 21st Century Cures Act, Public Law 114-255. Within available appropriations, the commissioner shall take steps to comply with the electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

Sec. 6. Minnesota Statutes 2024, section 256B.073, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have the meanings given them.

(b) "Data aggregator" means the entity designated by the commissioner to collect, store, and transmit electronic visit verification data from providers and third-party systems to the commissioner in accordance with the standards and requirements established under this section.

~~(b)~~ (c) "Electronic visit verification" or "EVV" means the ~~electronic documentation of the~~ process required under United States Code, title 42, section 1396b(l), and this section used to electronically verify:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; and

(6) time the service begins and ends.

(d) "Electronic visit verification data" means information collected through an electronic visit verification system, including data elements required under United States Code, title 42, section 1396b(l), and any additional data elements specified by the commissioner under this section.

~~(c)~~ (e) "Electronic visit verification system" means a system ~~that provides electronic verification of services~~ used to collect, verify, and transmit EVV data to the commissioner or the commissioner's designated data aggregator that complies with the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

(f) "Electronic visit verification vendor" means any entity that develops, provides, or supports an electronic visit verification system, including the state-provided vendor and any third-party vendor.

(g) "Financial management services provider" means an entity enrolled with the commissioner to provide financial management services under section 256B.85 or other applicable law and responsible for fiscal, payroll, and reporting functions on behalf of participant employers.

(h) "Individual" means a person who receives services subject to electronic visit verification under the medical assistance program.

(i) "Managed care organization" means a public or private organization that contracts with the commissioner under section 256B.69 or other applicable law to deliver health care services to individuals eligible for medical assistance or MinnesotaCare.

(j) "Provider" means an individual or organization that meets one or more of the following conditions:

(1) is enrolled as a Minnesota health care programs provider;

(2) provides services through a managed care organization under contract with the commissioner under section 256B.69;

(3) is a financial management services provider; or

(4) is a participant employer under section 256B.85, subdivision 7, or an employer of record directing services under section 256B.49, subdivision 16.

~~(d)~~ (k) "Service" means one of the following:

(1) personal care assistance services as defined in section 256B.0625, subdivision 19a, and provided according to section 256B.0659;

(2) community first services and supports under section 256B.85;

(3) home health services under section 256B.0625, subdivision 6a; ~~or~~

(4) all unit-based services delivered by a provider that is a provider type designated high-risk by the commissioner based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518;

(5) unit-based services that are designated high-risk by the commissioner; or

~~(4)~~ (6) other medical supplies and equipment or home and community-based services that are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

(l) "State-provided electronic visit verification system" means the electronic visit verification system made available by the commissioner to providers at no cost for services subject to federal electronic visit verification requirements.

(m) "Third-party electronic visit verification system" means an electronic visit verification system purchased or operated by a provider or vendor other than the state-provided system designated by the commissioner.

(n) "Verification method" means the electronic process used to capture and verify visit information, including telephone, fixed visit verification devices, or mobile applications, as approved by the commissioner.

(o) "Visit" means a single occurrence of service delivery subject to electronic visit verification.

(p) "Worker" means an individual who provides personal care assistance services, community first services and supports, home health services, consumer-directed community supports, or other services identified by the commissioner as subject to electronic visit verification.

Sec. 7. Minnesota Statutes 2024, section 256B.073, subdivision 3, is amended to read:

Subd. 3. **Requirements.** (a) In ~~developing implementation requirements for~~ administering electronic visit verification, the commissioner ~~shall~~ must ensure that the system and related requirements:

(1) are ~~minimally~~ administratively and financially ~~burdensome to a provider~~ reasonable for providers;

(2) ~~are minimally burdensome~~ support continued access to ~~the~~ services and are designed to avoid disruption to service ~~recipient and the least disruptive to the service recipient in receiving and maintaining allowed services~~ delivery or receipt;

(3) consider existing best practices and use of electronic visit verification;

(4) are conducted according to all state and federal laws;

(5) are effective methods for preventing fraud when balanced against the requirements of clauses (1) and (2); and

(6) are consistent with the Department of Human Services' policies related to covered services, flexibility of service use, and quality assurance.

(b) The commissioner ~~shall~~ must make training and guidance available to providers on the electronic visit verification ~~system~~ requirements and system use.

(c) The commissioner ~~shall~~ must establish baseline measurements related to preventing fraud and establish measures to determine the effect of electronic visit verification requirements on program integrity.

(d) The commissioner ~~shall~~ must make a state-selected electronic visit verification system available to providers of services.

(e) The commissioner ~~shall~~ must make available and publish on the agency website the name and contact information for the vendor of the state-selected electronic visit verification system and the other vendors that offer alternative electronic visit verification systems. The information provided must state that the state-selected electronic visit verification system is offered at no cost to the provider of services and that the provider may choose an alternative system that may be at a cost to the provider.

(f) The commissioner may establish implementation dates and implementation schedules for services or system functions subject to electronic visit verification under this section, including but not limited to the phased addition of new services, verification methods, or technical requirements.

(g) The commissioner may waive the requirements of this section for any service component or setting when the application of electronic visit verification is contrary to paragraph (a).

Sec. 8. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 4a. **Electronic visit verification system options.** (a) A provider must use an electronic visit verification system that complies with the requirements established by the commissioner. A provider may use either the state-provided system or a third-party system.

All systems used for compliance must provide data to the commissioner in the format and frequency required by the commissioner.

(b) The commissioner must make a state-provided electronic visit verification system available at no cost to providers of services. The commissioner must provide training on the system to all providers.

(c) The commissioner must allow providers of services to utilize a third-party electronic visit verification system that the commissioner determines meets the requirements of this section.

(d) A provider using a third-party electronic visit verification system that meets all technical specifications and federal and state laws must:

(1) collect and submit all data for each visit to the commissioner, including but not limited to manual entries;

(2) maintain compliance identified by the commissioner, including but not limited to incorporating into the system any changes in data requirements that must be transmitted to the state EVV system; and

(3) integrate the system with the state's designated data aggregator to accurately send data.

(e) The state-designated data aggregator must be available at no cost to a provider for purposes of transmitting electronic visit verification data from approved third-party systems to the commissioner. Any costs associated with the development and use of a third-party system are the responsibility of the provider.

(f) If a provider is unable to integrate a third-party system with the designated state aggregator, the provider must use the state EVV system.

(g) The commissioner must provide training on reviewing and correcting imported data in the state's designated data aggregator to providers.

Sec. 9. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 4b. **Provider responsibilities.** A provider must:

(1) use an electronic visit verification system that meets all technical and data submission requirements established by the commissioner;

(2) enroll with the state-provided electronic visit verification system or the commissioner's designated data aggregator, as applicable;

(3) provide all information requested by the commissioner for enrollment, access, and data submission and ensure that such information remains accurate and up to date;

(4) maintain records for each individual receiving services subject to electronic visit verification, including but not limited to all required data elements;

(5) maintain a current list of workers providing services subject to electronic visit verification to individuals receiving services under medical assistance;

(6) provide the commissioner and any managed care organization under contract with the commissioner under section 256B.69 with immediate, direct, and on-site or remote access to the electronic visit verification system;

(7) at the request of the commissioner or a managed care organization, allow review or copying of electronic visit verification documentation at no cost;

(8) ensure that electronic visit verification systems and related processes meet accessibility and confidentiality requirements under state and federal law;

(9) comply with all policies, procedures, and technical specifications issued by the commissioner under this section; and

(10) ensure that workers, participants, and other individuals using electronic visit verification are trained and comply with all documentation and data entry requirements established by the commissioner.

Sec. 10. Minnesota Statutes 2024, section 256B.073, subdivision 5, is amended to read:

Subd. 5. **Vendor requirements.** (a) The vendor of the electronic visit verification system selected by the commissioner and the vendor's affiliate must comply with the requirements of this subdivision.

(b) The vendor of the ~~state-selected~~ state-provided electronic visit verification system and the vendor's affiliate must:

(1) notify the provider of services that the provider may choose the ~~state-selected~~ state-provided electronic visit verification system at no cost to the provider;

(2) offer the ~~state-selected~~ state-provided electronic visit verification system to the provider of services prior to offering any fee-based electronic visit verification system;

(3) notify the provider of services that the provider may choose any fee-based electronic visit verification system prior to offering the vendor's or its affiliate's fee-based electronic visit verification system; and

(4) when offering the ~~state-selected~~ state-provided electronic visit verification system, clearly differentiate between the ~~state-selected~~ state-provided electronic visit verification system and the vendor's or its affiliate's alternative fee-based system.

(c) The vendor of the ~~state-selected~~ state-provided electronic visit verification system and the vendor's affiliate must not use state data that are not available to other vendors of electronic visit verification systems to promote or sell the vendor's or its affiliate's alternative electronic visit verification system.

(d) Upon request from the provider, the vendor of the ~~state-selected~~ state-provided electronic visit verification system must provide proof of compliance with the requirements of paragraph (b).

(e) An agreement between the vendor of the ~~state-selected~~ state-provided electronic visit verification system or its affiliate and a provider of services for an electronic visit verification system that is not the ~~state-selected~~ state-provided system entered into on or after July 1, 2023, is subject to immediate termination by the provider if the vendor violates any of the requirements of paragraph (b).

Sec. 11. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 6. **Data and documentation.** (a) A provider must submit electronic visit verification data to the commissioner or the commissioner's designated data aggregator in accordance with the technical standards, format, and frequency established under this section. The commissioner may use integrated electronic visit verification data for oversight, quality assurance, and program integrity purposes consistent with state and federal law.

(b) The commissioner and managed care organizations must use electronic visit verification data to validate claims for payment under medical assistance. Claims that cannot be validated in accordance with electronic visit verification requirements may be subject to actions by the commissioner as authorized under state and federal law, including actions related to payment, program integrity, or provider compliance.

(c) A provider must record all required electronic visit verification data at the time of service delivery using an approved verification method. To be compliant with electronic

visit verification requirements, a provider must document a visit with all required data elements recorded at the time of service delivery.

(d) A manual visit is a visit:

(1) entered administratively and not by the caregiver at the time of service delivery; or

(2) where data elements are edited after the time of service delivery.

(e) A manual visit does not comply with electronic visit verification requirements. A manual visit must be confirmed and verified according to processes established by the commissioner before being used to validate or support a claim for payment.

(f) A worker providing services subject to electronic visit verification must record the start and end times of each visit at the time the service is delivered using an approved verification method. A worker must complete and verify all time documentation, including but not limited to verification of service type, date, and duration, on the date the service occurs and be consistent with documentation requirements under sections 256B.0625, subdivision 6a; 256B.0659, subdivision 12; 256B.49, subdivision 16; and 256B.85, subdivision 15. A provider of services must maintain documentation demonstrating compliance with this subdivision and make the documentation available to the commissioner or a managed care organization under contract with the commissioner under section 256B.69 upon request.

Sec. 12. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision to read:

Subd. 7. **Third-party system responsibilities.** (a) This section is effective for Early Intensive Developmental and Behavioral Intervention services beginning July 1, 2027, or upon federal approval, whichever is later. This section is effective for all other services subject to this subdivision beginning January 1, 2027, or upon federal approval, whichever is later.

(b) A provider that uses a third-party electronic visit verification system must ensure that the system meets all technical, functional, and data-exchange requirements established by the commissioner and transmits data to the commissioner or the commissioner's designated data aggregator in the format and frequency required by the commissioner.

(c) A third-party electronic visit verification vendor must:

(1) comply with all technical, contractual, privacy, and security standards established by the commissioner;

(2) not use or disclose state data for any purpose other than fulfilling the requirements of this section or federal law;

(3) provide the commissioner access to system documentation, data mapping, and audit records upon request; and

(4) immediately report to the commissioner any data transmission failure, breach, or interruption affecting the state's ability to receive required electronic visit verification data.

(d) A provider remains responsible for ensuring compliance with this section even when using a third-party electronic visit verification system.

(e) The third-party vendor must ensure training on the system is available to providers.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 13. Minnesota Statutes 2025 Supplement, section 256B.0911, subdivision 14, is amended to read:

Subd. 14. **Use of MnCHOICES certified assessors required.** (a) Each lead agency shall use MnCHOICES certified assessors who have completed MnCHOICES training and the certification process determined by the commissioner in subdivision 13.

(b) Each lead agency must ensure that the lead agency has sufficient numbers of certified assessors to provide long-term consultation assessment and support planning within the timelines and parameters of the service.

(c) A lead agency may choose, according to departmental policies, to contract with a qualified, certified assessor to conduct assessments and reassessments on behalf of the lead agency.

(d) Tribes and health plans under contract with the commissioner must provide long-term care consultation services as specified in the contract.

(e) A lead agency must provide the commissioner with an administrative contact for communication purposes.

(f) A lead agency may contract under this subdivision with any hospital licensed under sections 144.50 to 144.56 to conduct assessments of patients in the hospital on behalf of the lead agency when the lead agency has failed to meet its obligations under subdivision 17. The contracted assessment must be conducted by a hospital employee who is a qualified, certified assessor. The hospital employees who perform assessments under the contract between the hospital and the lead agency may perform assessments in addition to other duties assigned to the employee by the hospital, except the hospital employees who perform

the assessments under contract with the lead agency must not perform any waiver-related tasks other than assessments. Hospitals are not eligible for reimbursement under subdivision 33. The lead agency that enters into a contract with a hospital under this paragraph is responsible for oversight, compliance, and quality assurance for all assessments performed under the contract.

(g) The commissioner must employ certified assessors within the department to conduct assessments on behalf of lead agencies under conditions and circumstances determined by the commissioner. Certified assessors employed by the department may conduct assessments in addition to other duties as assigned, except the certified assessors employed by the department must not perform any responsibilities of a lead agency described in this section other than assessments. Nothing in this paragraph creates an obligation for the department to provide the department's certified assessors to conduct assessments on behalf of a lead agency.

Sec. 14. Minnesota Statutes 2024, section 256B.0911, subdivision 32, is amended to read:

Subd. 32. **Administrative activity.** (a) The commissioner shall:

(1) streamline the processes, including timelines for when assessments need to be completed;

(2) provide the services in this section; ~~and~~

(3) implement integrated solutions to automate the business processes to the extent necessary for support plan approval, reimbursement, program planning, evaluation, and policy development~~.~~; and

(4) grant limited role-based access to a person's support plan in the MnCHOICES system to home and community-based service providers who have been designated as a provider for that person by a lead agency for the purpose of signing the person's support plan electronically and demonstrating that the provider has reviewed, understood, and agrees to deliver services as outlined in the plan.

(b) The commissioner shall work with lead agencies responsible for conducting long-term care consultation services to:

(1) modify the MnCHOICES application and assessment policies to create efficiencies while ensuring federal compliance with medical assistance and long-term services and supports eligibility criteria; and

(2) develop a set of measurable benchmarks sufficient to demonstrate quarterly improvement in the average time per assessment and other mutually agreed upon measures of increasing efficiency.

(c) The commissioner shall collect data on the benchmarks developed under paragraph (b) and provide to the lead agencies an annual trend analysis of the data in order to demonstrate the commissioner's compliance with the requirements of this subdivision.

Sec. 15. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision to read:

Subd. 19. **Billing limits.** (a) Effective July 1, 2027, or upon federal approval, whichever is later, the following billing limits apply to early intensive development and behavioral intervention services:

(1) intensive services: 40 hours per week per recipient;

(2) travel: two hours per day per recipient;

(3) observation and direction: 20 hours per week per recipient; and

(4) individual treatment and planning: 300 units per year per recipient.

(b) The commissioner must grant exceptions to the billing limits under paragraph (a) when services in excess of the billing limits are determined to be medically necessary. A provider must apply to the commissioner for an exception on the forms and in the manner prescribed by the commissioner. A determination under this paragraph is final and not subject to appeal.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 16. Minnesota Statutes 2024, section 256B.4905, subdivision 11, is amended to read:

Subd. 11. **Informed choice in technology policy.** It is the policy of this state that all adults who have disabilities and children who have disabilities:

(1) can use assistive technology, remote supports, or a combination of both to enhance the adult's or child's independence and quality of life; and

(2) have the right, at least annually, to make an informed choice about the adult's or child's use of assistive technology and remote supports when permitted under the individual's federally approved waiver plan, service authorization, and applicable service standards.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 17. Minnesota Statutes 2024, section 256B.4905, subdivision 12, is amended to read:

Subd. 12. **Informed choice and technology prioritization in implementation for disability waiver services.** (a) The commissioner of human services shall ensure that:

(1) disability waivers under sections 256B.092 and 256B.49 support the presumption that all adults who have disabilities and children who have disabilities may use assistive technology, remote supports, or both to enhance the adult's or child's independence and quality of life; ~~and~~

(2) each individual accessing waiver services is offered, after an informed decision-making process and during a person-centered planning process, the opportunity to choose assistive technology, remote support, or both prior to the commissioner offering or reauthorizing services that utilize direct support staff to ensure equitable access~~.~~; and

(3) policies and procedures related to the use of technology, including but not limited to remote support, promote informed choice and protect the health and safety of individuals receiving services consistent with federal law and the terms of approved waiver plans.

(b) Nothing in this subdivision authorizes the use of remote support as a method of service delivery unless expressly permitted under the applicable service definition, waiver plan, and service standards approved by the Centers for Medicare and Medicaid Services.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 18. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision to read:

Subd. 17. **Billing limits.** (a) The limits in this subdivision establish the maximum amounts of authorized units for each service within a service day, week, or month.

(b) Effective January 1, 2027, or upon federal approval, whichever is later, the following billing limits apply:

(1) adult companion services: up to six hours per day per recipient with a maximum of 963 hours annually;

(2) chore services: up to six hours per week per recipient for 15-minute units;

(3) homemaker services, cleaning: up to 16 hours per week per recipient;

(4) homemaker services, home management: up to 16 hours per week per recipient;

(5) day support services: up to eight hours per day per recipient;

(6) family training and counseling under a disability waiver: up to two hours per week per recipient or family unit;

(7) community residential services one-to-one staffing: the maximum daily hours permitted under the applicable service tier under section 256B.4914, as published by the commissioner;

(8) independent living skills: up to six hours per day per recipient;

(9) individualized home supports with family training: six total hours per day;

(10) individualized home supports with training: up to 182.5 hours per month;

(11) home-delivered meals: up to two meals per day per recipient;

(12) individualized home supports: up to 16 hours per day per recipient, inclusive of all staffing ratios;

(13) personal emergency response system: one unit per month per recipient, inclusive of installation, monitoring, and maintenance;

(14) respite services provided in the recipient's home: 30 consecutive days per occurrence;

(15) overnight supervision services: ten hours per day per recipient, with no more than eight hours asleep; and

(16) transportation services: 28 one-way trips per week per participant.

(c) For personal emergency response system billing units under paragraph (b), clause (13), lead agency staff must end service lines for any inactive providers to prevent duplicate billing.

(d) The limits in this subdivision do not limit a person's use of other waiver services. Billing limits under this subdivision apply only to the individual service listed and do not prohibit the recipient from accessing other services for which they are eligible on the same day, week, or month, subject to other applicable requirements.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 19. Minnesota Statutes 2024, section 256B.4914, subdivision 6d, is amended to read:

Subd. 6d. **Payment for customized living.** (a) The payment methodology for customized living and 24-hour customized living must be the customized living tool. The commissioner shall revise the customized living tool to reflect the services and activities unique to disability-related recipient needs and adjust for regional differences in the cost of providing services.

(b) The rate adjustments described in section 256S.205 do not apply to rates paid under this section.

(c) Customized living and 24-hour customized living rates determined under this section shall not include more than 24 hours of support in a daily unit.

(d) The commissioner shall establish the following acuity-based customized living tool input limits, based on case mix, for customized living and 24-hour customized living rates determined under this section:

(1) no more than two hours of mental health management per day for people assessed for case mixes A, D, and G;

(2) no more than four hours of activities of daily living assistance per day for people assessed for case mix B; and

(3) no more than six hours of activities of daily living assistance per day for people assessed for case mix D.

(e) Customized living monthly service rate limits must align with monthly service rate limits determined under section 256S.202, subdivisions 1 and 2.

Sec. 20. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision to read:

Subd. 10e. **Documentation of staffing; auditing and rate review.** (a) Effective for services provided on or after January 1, 2029, a provider enrolled to provide residential support services under subdivision 6 must maintain documentation of direct staffing hours provided to each person receiving services, including but not limited to documentation identifying:

(1) the name, role, and unique identifier for each staff person who provided services to match records to payroll, time and attendance systems, and any other source documentation;

(2) the date services were provided;

(3) the total number of hours of direct support provided;

(4) awake overnight staffing hours provided, if applicable;

(5) asleep overnight staffing hours provided, if applicable; and

(6) any other staffing information required by the commissioner.

(b) A provider must maintain documentation in a manner and format determined by the commissioner for at least six years. If a provider changes payroll vendors, merges operations,

or changes staffing identifiers, the provider must maintain a documented link between prior and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and role classification for each staff person.

(c) A provider must submit the documentation required under paragraph (a) to the commissioner annually, in a manner and format determined by the commissioner. The commissioner must establish multiple submission windows throughout the calendar year and may assign providers to a submission window for administrative efficiency and system capacity. Documentation must reflect staffing provided during the prior calendar year and must be submitted no later than the final business day of the provider's assigned submission window. The commissioner may conduct random or targeted validations and audits of submitted data and may require supplemental documentation as necessary to verify accuracy and compliance.

(d) The commissioner must conduct periodic analysis of documentation submitted under this subdivision and may validate staffing data through random audits or other verification methods.

(e) Based on the analysis under paragraph (d), the commissioner may provide recommendations to lead agencies regarding modifications to the rate of a person receiving services, including increases or decreases necessary to align the rate with staffing provided to the person as demonstrated by the submitted historical staffing documentation. Recommendations must be based on the requirements of this section and applicable federal and state requirements governing rate setting.

(f) If a provider fails to submit documentation requested within the submission window in paragraph (c), the commissioner must issue a written notice of noncompliance. If documentation is not received within 60 days following the notice of noncompliance, the commissioner may temporarily suspend payments to the provider until the required documentation is submitted. The commissioner must make withheld payments to the provider once the required documentation is received. If the noncompliance persists, the commissioner may adjust future rate payments, require the provider to submit a corrective action plan, or pursue other enforcement actions as authorized by law.

(g) The commissioner must publish annual aggregate reports summarizing audit findings and trends related to staffing provided under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 21. Minnesota Statutes 2024, section 256B.492, is amended by adding a subdivision to read:

Subd. 4. **Integrated community supports setting approval moratorium and exception.** (a) For purposes of this subdivision, "integrated community supports setting" means a multifamily housing building where a provider delivers integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause (8), and for which a provider has a provider-controlled or provider-associated financial interest as defined under section 245A.02, subdivision 10b.

(b) The commissioner must not approve a new integrated community supports setting or approve an expansion of an existing integrated community supports setting except as provided in this subdivision.

(c) The commissioner may approve an exception to the moratorium only when the applicant demonstrates indirect control of the setting and compliance with:

(1) the federal home and community-based services requirements under Code of Federal Regulations, title 42, section 441.301(c);

(2) the prohibition on the use of medical assistance money for room and board under United States Code, title 42, section 1396n(c);

(3) independent lease requirements consistent with chapter 504B; and

(4) all documentation requirements under section 245D.12.

(d) To approve an exception, the commissioner must determine that the lead agency has requested the additional capacity to meet the specific disability-related needs of the person. Priority must be given to geographic regions with insufficient integrated community supports capacity based on statewide or regional needs determination processes.

(e) A determination under this subdivision is final and not subject to appeal.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 22. Minnesota Statutes 2024, section 256S.20, is amended by adding a subdivision to read:

Subd. 6. **Customized living and 24-hour customized living moratorium.** (a) Except as permitted in this subdivision, the commissioner must not authorize:

(1) a new customized living setting or 24-hour customized living setting; or

(2) a new provider enrollment to deliver customized living services or 24-hour customized living services.

(b) The commissioner may approve an exception to the moratorium only when the commissioner determines the exception is necessary for:

(1) a change of ownership at the same address;

(2) continuity of care due to a provider closure, decertification, licensing action, or other service disruption; or

(3) compliance with federal law.

(c) In determining whether to approve an exception to the moratorium, the commissioner must consider the availability of services in the geographic area, a person's assessed needs and informed choice, whether a less restrictive alternative is available, and the recommendation of the lead agency.

(d) A determination under this subdivision is final and not subject to appeal.

EFFECTIVE DATE. This section is effective January 1, 2027.

Sec. 23. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision to read:

Subd. 4. **Documentation of staffing; auditing and rate review for residential support services.** (a) For purposes of this subdivision, residential support services include 24-hour customized living services, customized living services, family adult foster care, and corporate adult foster care.

(b) Effective January 1, 2029, a provider enrolled to provide residential support services under this subdivision must maintain documentation of direct staffing hours provided to each person receiving services, including but not limited to documentation identifying:

(1) the name, role, and unique identifier for each staff person who provided services to match records to payroll, time and attendance systems, and any other source documentation;

(2) the date services were provided;

(3) the total number of hours of direct support provided;

(4) awake overnight staffing hours provided, if applicable;

(5) asleep overnight staffing hours provided, if applicable; and

(6) any other staffing information required by the commissioner.

(c) A provider must maintain documentation in a manner and format determined by the commissioner for at least six years. If a provider changes payroll vendors, merges operations, or changes staffing identifiers, the provider must maintain a documented link between prior and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and role classification for each staff person.

(d) A provider must submit the documentation required under paragraph (b) to the commissioner annually, in a manner and format determined by the commissioner. The commissioner must establish multiple submission windows throughout the calendar year and may assign providers to a submission window for administrative efficiency and system capacity. Documentation must reflect staffing provided during the prior calendar year and must be submitted no later than the final business day of the provider's assigned submission window. The commissioner may conduct random or targeted validations and audits of submitted data and may require supplemental documentation as necessary to verify accuracy and compliance.

(e) The commissioner must conduct periodic analysis of documentation submitted under this subdivision and may validate staffing data through random audits or other verification methods.

(f) Based on the analysis under paragraph (e), the commissioner may provide recommendations to lead agencies regarding modifications to the rate of the person receiving services, including increases or decreases necessary to align the rate with staffing provided to the person as demonstrated by the submitted historical staffing documentation. Recommendations must be based on the requirements of this section and applicable federal and state requirements governing rate setting.

(g) If a provider fails to submit documentation requested within the submission window under paragraph (d), the commissioner must issue a written notice of noncompliance. If documentation is not received within 60 days following the notice of noncompliance, the commissioner may temporarily suspend payments to the provider until the required documentation is submitted. The commissioner must make withheld payments to the provider once the required documentation is received. If the noncompliance persists, the commissioner may adjust future rate payments, require the provider to submit a corrective action plan, or pursue other enforcement actions as authorized by law.

(h) The commissioner must publish annual aggregate reports summarizing audit findings and trends related to staffing provided under this section.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 24. **MARKET RATE STUDY FOR HOME AND COMMUNITY-BASED SERVICES.**

(a) The commissioner of human services must conduct a market rate study to evaluate the adequacy, sustainability, and equity of payment rates for specific home and community-based services under the home and community-based services waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49.

(b) The study must include, at a minimum, an analysis of the following:

(1) employment support services delivered in remote or virtual settings;

(2) 24-hour emergency assistance;

(3) assistive technology;

(4) environmental accessibility adaptations;

(5) chore services;

(6) transitional services;

(7) independent living skills training;

(8) specialist services, including positive support services and orientation and mobility services; and

(9) administrative fees charged by enrolled providers or vendors for services or purchased goods.

(c) In planning and conducting the market rate study, the commissioner must consult with interested parties, including but not limited to service providers, people with disabilities, lead agencies, Tribal Nations, culturally specific and community-based providers, and disability advocacy organizations. The consultation process must be designed to ensure meaningful participation from providers in greater Minnesota and from providers serving communities of color and Tribal Nations.

(d) In conducting the study, the commissioner must analyze provider costs, workforce availability, wage competitiveness, regional market conditions, inflationary impacts, and access issues. The commissioner must also evaluate whether current reimbursement methodologies reflect actual costs of providing services and support long-term access to qualified providers.

(e) By February 15, 2027, the commissioner must submit a report with findings and recommendations, including but not limited to any proposed statutory changes, to the chairs

and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 25. **WAIVER CASE MANAGEMENT ADVISORY WORKING GROUP.**

Subdivision 1. **Establishment; purpose.** The commissioner of human services shall convene a waiver case management advisory working group. The purpose of the working group is to evaluate and make recommendations regarding the quality, workforce sustainability, accountability, and long-term stability of home and community-based waiver case management services provided under Minnesota Statutes, sections 256B.0913, 256B.092, 256B.0922, and 256B.49, and chapter 256S.

Subd. 2. **Membership.** The commissioner shall appoint members representing diverse geographic regions of the state, including metropolitan and greater Minnesota areas, with at least 30 percent of the members living or working outside the seven-county metropolitan area and including:

(1) representatives of the Department of Human Services;

(2) lead agencies, as defined in Minnesota Statutes, section 256B.0911, subdivision 10;

(3) contracted waiver case management providers;

(4) waiver case managers with current direct service responsibilities;

(5) individuals receiving waiver services or their family members or advocates;

(6) representatives of disability advocacy organizations;

(7) representatives of the Minnesota Disability Law Center;

(8) representatives of culturally specific or Tribal communities; and

(9) workforce representatives with experience in human services.

Subd. 3. **Compensation; expenses.** Members of the working group may receive compensation and expense reimbursement as provided in Minnesota Statutes, section 15.059, subdivision 3.

Subd. 4. **Meetings; administrative support.** (a) The first meeting of the working group must be convened no later than August 1, 2026. The working group must meet at least monthly. Meetings are subject to Minnesota Statutes, chapter 13D. The working group may meet by telephone or interactive technology consistent with Minnesota Statutes, section 13D.015.

(b) The Department of Human Services shall provide staff and administrative support to convene the working group, facilitate working group meetings, and prepare the final report.

Subd. 5. **Duties.** The working group shall:

(1) evaluate the impact of current funding levels, workforce capacity, administrative requirements, and caseload expectations on service delivery and quality outcomes;

(2) examine accountability and oversight mechanisms and grievance processes across delivery models;

(3) review available data related to workforce vacancies, turnover, compensation, and service access;

(4) identify barriers to maintaining high-quality and culturally responsive case management services;

(5) examine case management training requirements and core competencies;

(6) evaluate client transfer and service continuity processes; and

(7) develop recommendations, including potential legislative or administrative changes, to ensure a stable, accountable, and high-quality waiver case management system that supports person-centered planning and informed choice.

Subd. 6. **Report.** By September 1, 2027, the commissioner shall submit a report summarizing the working group's findings and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance.

Subd. 7. **Expiration.** The working group expires upon submission of the report required under subdivision 6.

EFFECTIVE DATE. This section is effective July 1, 2026.

Sec. 26. **DIRECTION TO COMMISSIONER; HCBS WAIVER CASE MANAGEMENT EVALUATION AND REPORT.**

(a) The commissioner of human services must evaluate reimbursement rates and lead agency duties associated with home and community-based services (HCBS) case management under Minnesota Statutes, sections 256B.092 and 256B.49, and chapter 256S. The commissioner must develop an updated payment methodology for waiver case management

that reasonably covers the cost to provide high-quality, person-centered, and culturally responsive case management services. The report must, at a minimum, include:

(1) an evaluation of costs and workforce pressures that impact the delivery of case management services;

(2) an evaluation of costs to provide culturally responsive case management services;

(3) an evaluation of current reimbursement rates, methodologies, and the extent to which rates cover costs to provide services and attract and retain case managers;

(4) an evaluation of current caseload sizes and recommended best practices for caseload and case mix;

(5) identification and evaluation of the required professional qualifications, experience, and training of case management professionals; and

(6) recommended HCBS waiver rate methodology, specified cost components, weighted values, and modeled rate frameworks.

(b) The commissioner must consult with interested parties, including but not limited to lead agencies, contracted case management services providers, individuals receiving services and their families, advocacy organizations, and relevant experts. The commissioner must consider the recommendations of the waiver case management advisory working group under section 25 when developing recommendations under this section.

(c) The commissioner may contract with rate experts to develop and model recommended rates.

(d) By December 15, 2028, the commissioner of human services must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services with the findings and recommendations of the evaluation.

EFFECTIVE DATE. This section is effective July 1, 2027.

Sec. 27. **INTEGRATED COMMUNITY SUPPORTS REFORM STUDY.**

Subdivision 1. **Review and evaluation.** The commissioner of human services must review the medical assistance integrated community supports (ICS) service provided under the home and community-based waivers authorized under Minnesota Statutes, sections 256B.092 and 256B.49, and evaluate the need for statutory, regulatory, and programmatic reforms. At a minimum, the evaluation must include:

(1) an examination of current provider standards, service delivery models, and oversight mechanisms applicable to ICS providers;

(2) an assessment of the effectiveness of ICS in supporting individuals to live independently in community settings, including outcomes related to service utilization and health and safety;

(3) a review of payment methodologies, including rate structures, administrative components, and alignment with federal Medicaid requirements under home and community-based services waivers and state plan authorities;

(4) an environmental scan of comparable supportive housing and community-based service models in other states, including best practices for program integrity, quality assurance, and service coordination;

(5) an assessment of program integrity risks, including billing practices and service verification; and

(6) identification of opportunities to improve coordination between ICS providers and lead agencies.

Subd. 2. **Stakeholder consultation.** The commissioner must consult with stakeholders in conducting the review under this section. Stakeholders must include, at a minimum:

(1) individuals who receive ICS services and self-advocates;

(2) family members and caregivers of individuals who receive ICS services;

(3) ICS providers;

(4) counties and Tribal Nations serving as lead agencies; and

(5) advocacy organizations representing people with disabilities.

Subd. 3. **Report.** (a) The commissioner must develop recommendations for legislative and administrative changes to strengthen the ICS program. Recommendations may include but are not limited to:

(1) establishing risk-based provider oversight and program integrity requirements;

(2) clarifying allowable services and service limits consistent with federal Medicaid requirements, including prohibitions on payment for room and board;

(3) improving service verification, documentation, and accountability measures;

(4) enhancing recipient protections, including person-centered planning and grievance processes; and

(5) aligning ICS with home and community-based services settings requirements under Code of Federal Regulations, title 42, section 441.301.

(b) The commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by September 1, 2027. The report must include findings, stakeholder feedback, and specific legislative proposals related to ICS reform.

Sec. 28. **MNCHOICES REDESIGN WORKING GROUP.**

Subdivision 1. **Establishment.** The commissioner of human services shall convene a MnCHOICES redesign working group to develop recommendations related to state provision of MnCHOICES assessments under Minnesota Statutes, section 256B.0911, subdivision 14, paragraph (g).

Subd. 2. **Membership.** At a minimum, the working group must include the following members:

(1) two individuals receiving waiver services or the individuals' family members or advocates, appointed by the commissioner in consultation with organizations representing individuals with lived experience of disability and waiver services;

(2) three county representatives, appointed by the Minnesota Association of County Social Service Administrators, including;

(i) at least one representative of a lead agency located in a metropolitan county, as defined in Minnesota Statutes, section 473.121, subdivision 4; and

(ii) at least two representatives of lead agencies located outside of a metropolitan county, as defined in Minnesota Statutes, section 473.121, subdivision 4;

(3) one staff member from the Minnesota Social Service Association, appointed by the Minnesota Social Service Association;

(4) at least three representatives from Tribal Nations, appointed by the commissioner;

(5) two representatives of disability advocacy organizations, appointed by the commissioner;

(6) one representative of aging services organizations, appointed by LeadingAge Minnesota;

(7) one representative of aging services organizations, appointed by Care Providers of Minnesota; and

(8) additional nonvoting participants as determined by the commissioner, which may include staff from the Department of Human Services and other interested parties.

Subd. 3. **Duties.** The working group shall make recommendations to shift the responsibility and administration of conducting MnCHOICES assessments to the state. Recommendations must include:

(1) defined roles and responsibilities between county, Tribal Nation, and state functions;

(2) revised payment methodologies and financing of duties;

(3) efficient workflows between local and state functions;

(4) service continuity for people seeking and receiving long-term services and supports; and

(5) methods for gathering public feedback and providing public awareness.

Subd. 4. **Terms, compensation, and removal.** The terms, compensation, and removal of the working group members are governed by Minnesota Statutes, section 15.059.

Subd. 5. **Meetings; administrative support.** (a) The first meeting of the working group must be convened no later than August 1, 2026. The working group must meet at least monthly. The working group may meet by telephone or interactive technology consistent with Minnesota Statutes, section 13D.015.

(b) The Department of Human Services shall provide staff and administrative support to convene the working group, facilitate working group meetings, and prepare the final report.

Subd. 6. **Report.** By September 1, 2027, the commissioner must submit a report of the working group's findings and recommendations, including but not limited to any legislative changes necessary to implement the recommendations, to the chairs and ranking minority members of the legislative committees with jurisdiction over human services policy and finance.

Subd. 7. **Expiration.** The working group expires upon submission of the report required under subdivision 6.

Sec. 29. **REPEALER.**

Minnesota Statutes 2024, section 256B.073, subdivision 4, is repealed.

EFFECTIVE DATE. This section is effective July 1, 2026.

ARTICLE 7
MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 8.16, subdivision 1, is amended to read:

Subdivision 1. **Authority.** (a) The attorney general, or any deputy, assistant, or special assistant attorney general whom the attorney general authorizes in writing, has the authority in any county of the state to subpoena and require the production of: (1) any records of: (i) telephone companies, cellular phone companies, and paging companies~~,~~; (ii) subscribers of private computer networks, including Internet service providers or computer bulletin board systems~~,~~; (iii) electric companies, gas companies, and water utilities~~,~~; (iv) chemical suppliers~~,~~; (v) hotels and motels~~,~~; (vi) pawn shops~~,~~; (vii) airlines, buses, taxis, and other entities engaged in the business of transporting people~~,~~; and (viii) freight companies, self-service storage facilities, warehousing companies, package delivery companies, and other entities engaged in the businesses of transport, storage, or delivery~~, and~~; (2) wage and employment records; (3) records of the existence of safe deposit box account numbers and customer savings and checking account numbers maintained by financial institutions and safe deposit companies; (4) insurance records related to claim settlement; and (5) banking, credit card, and financial records, including but not limited to a safe deposit, loan and account application and agreement, signature card, statement, check, transfer, account authorization, safe deposit access record, and documentation of fraud, that belong to the subject of an investigation conducted pursuant to the attorney general's authority under section 256B.12, whether the record is held in the investigation subject's name or in another person's name.

(b) Subpoenas may only be issued for records that are relevant to an ongoing legitimate law enforcement investigation.

Sec. 2. Minnesota Statutes 2025 Supplement, 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~~ $13,500,000 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,~~ 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.

Sec. 3. Minnesota Statutes 2024, section 144G.41, subdivision 1, is amended to read:

Subdivision 1. **Minimum requirements.** All assisted living facilities shall:

(1) distribute to residents the assisted living bill of rights;

(2) provide services in a manner that complies with the Nurse Practice Act in sections 148.171 to 148.285;

(3) utilize a person-centered planning and service delivery process;

(4) have and maintain a system for delegation of health care activities to unlicensed personnel by a registered nurse, including supervision and evaluation of the delegated activities as required by the Nurse Practice Act in sections 148.171 to 148.285;

(5) except as specified in subdivision 1c, provide a means for residents to request assistance for health and safety needs 24 hours per day, seven days per week. A facility may use person-centered strategies to provide a means for residents to request assistance and, if effective, may allow residents to use technological devices to request assistance;

(6) allow residents the ability to furnish and decorate the resident's unit within the terms of the assisted living contract;

(7) permit residents access to food at any time;

(8) allow residents to choose the resident's visitors and times of visits;

(9) allow the resident the right to choose a roommate if sharing a unit;

(10) notify the resident of the resident's right to have and use a lockable door to the resident's unit. The licensee shall provide the locks on the unit. Only a staff member with a specific need to enter the unit shall have keys, and advance notice must be given to the

resident before entrance, when possible. An assisted living facility must not lock a resident in the resident's unit;

(11) develop and implement a staffing plan for determining its staffing level that:

(i) includes an evaluation, to be conducted at least twice a year, of the appropriateness of staffing levels in the facility;

(ii) ensures sufficient staffing at all times to meet the scheduled and reasonably foreseeable unscheduled needs of each resident as required by the residents' assessments and service plans on a 24-hour per day basis; and

(iii) ensures that the facility can respond promptly and effectively to individual resident emergencies and to emergency, life safety, and disaster situations affecting staff or residents in the facility;

(12) ensure that one or more persons are available 24 hours per day, seven days per week, who are responsible for responding to the requests of residents for assistance with health or safety needs. Such persons must be:

(i) awake;

(ii) located in the same building, in an attached building, or on a contiguous campus with the facility in order to respond within a reasonable amount of time;

(iii) capable of communicating with residents;

(iv) capable of providing or summoning the appropriate assistance; and

(v) capable of following directions; and

(13) provide staff access to an on-call registered nurse 24 hours per day, seven days per week.

Sec. 4. Minnesota Statutes 2024, section 144G.41, is amended by adding a subdivision to read:

Subd. 1c. **Alternative to summoning device to request assistance.** For a resident who, based on an individualized nursing assessment under section 144G.70, subdivision 2, cannot reliably use a summoning device such as a phone, bell, call light, pull cord, or pendant to request assistance for health and safety needs, a facility:

(1) is not required to have a resident use a summoning device to request assistance for health and safety needs; and

(2) must use person-centered strategies to meet the resident's assessed needs.

Sec. 5. Minnesota Statutes 2025 Supplement, 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 county agency in all matters pertaining hereto. To prosecute under this chapter or sections ~~609.466~~ 609.467; 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. 6. Minnesota Statutes 2024, section 295.50, subdivision 4, is amended to read:

Subd. 4. **Health care provider.** (a) "Health care provider" means:

(1) a person whose health care occupation is regulated or required to be regulated by the state of Minnesota furnishing any or all of the following goods or services directly to a patient or consumer: medical, surgical, optical, visual, dental, hearing, nursing services, drugs, laboratory, diagnostic or therapeutic services;

(2) a person who provides goods and services not listed in clause (1) that qualify for reimbursement under the medical assistance program provided under chapter 256B;

(3) a staff model health plan company;

(4) an ambulance service required to be licensed;

(5) a person who sells or repairs hearing aids and related equipment or prescription eyewear; or

(6) a person providing patient services, who does not otherwise meet the definition of health care provider and is not specifically excluded in ~~clause~~ paragraph (b), who employs or contracts with a health care provider as defined in clauses (1) to (5) to perform, supervise, otherwise oversee, or consult with regarding patient services.

(b) Health care provider does not include:

(1) hospitals; medical supplies distributors, except as specified under paragraph (a), clause (5); nursing homes licensed under chapter 144A or licensed in any other jurisdiction; wholesale drug distributors; pharmacies; surgical centers; bus and taxicab transportation, or any other providers of transportation services other than ambulance services required to be licensed; 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~~ assisted living facilities licensed under chapter 144G; 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; and adult day care centers as defined in Minnesota Rules, part 9555.9600;

(2) home health agencies as defined in Minnesota Rules, part 9505.0175, subpart 15; a person providing personal care assistance services and supervision of personal care assistance services as defined in ~~Minnesota Rules, part 9505.0335~~ section 256B.0625, subdivision 19a; a person providing home care nursing services as defined in Minnesota Rules, part 9505.0360; and home care providers required to be licensed under chapter 144A for home care services provided under chapter 144A;

(3) a person who employs health care providers solely for the purpose of providing patient services to its employees;

(4) an educational institution that employs health care providers solely for the purpose of providing patient services to its students if the institution does not receive fee for service payments or payments for extended coverage; and

(5) a person who receives all payments for patient services from health care providers, surgical centers, or hospitals for goods and services that are taxable to the paying health care providers, surgical centers, or hospitals, as provided under section 295.53, subdivision 1, paragraph (b), clause (3) or (4), or from a source of funds that is excluded or exempt from tax under sections 295.50 to 295.59.

Sec. 7. Minnesota Statutes 2025 Supplement, 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 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~~ assisted living facilities licensed under chapter 144G; 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.

Sec. 8. **[609.467] MEDICAL ASSISTANCE FRAUD.**

Subdivision 1. **Medical assistance fraud prohibited.** A person who does any of the following is guilty of medical assistance fraud and may be sentenced as provided in subdivision 2:

(1) acting with intent to defraud, executes or participates in, or attempts or conspires to execute or participate in, a scheme or artifice to obtain, by means of any false or fraudulent pretenses, representations, or promises, or concealment of any material fact, any money or credits relating to the payment of medical assistance funds under chapter 256B;

(2) acting with intent to defraud, presents, submits, tenders, offers, or participates in, or attempts or conspires to execute or participate in, the preparation of a claim for payment, claim for reimbursement, cost report, or rate application, knowing or having reason to know that any part of the claim, report, or application is ineligible for payment or reimbursement;

(3) acting with intent to defraud, knowingly provides false information or intentionally omits material information as part of any enrollment application, provider agreement, or ownership and management disclosure required by any state or federal law as a medical assistance provider under chapter 245A or 256B;

(4) owns, operates, manages, or exercises control over any entity receiving medical assistance money, while knowing or having reason to know that the person has been suspended or prohibited from enrolling as a medical assistance provider by any state agency or under any state law or is excluded or prohibited from enrolling as a medical assistance provider by any federal agency or under any federal law;

(5) knowingly and intentionally permits another person to own, operate, manage, or exercise control over any entity receiving medical assistance money, while knowing or having reason to know the other person is suspended or prohibited from enrolling as a

medical assistance provider by any state agency or under any state law or is excluded or prohibited from enrolling as a medical assistance provider by any federal agency or under any federal law;

(6) falsely makes or alters any record relating to the delivery of medical assistance services so that the record purports to have been made by another person or by the maker or alterer under an assumed or fictitious name, or at another time, or with different provisions, or by the authority of a person who did not give such authority;

(7) acting with intent to defraud, presents, submits, tenders, offers, or participates in, or attempts or conspires to participate in, the preparation of a claim for reimbursement for personal care assistance services under section 256B.0659 or community first services and supports under section 256B.85, knowing or having reason to know that required conditions for payment under chapter 256B were not met, including applicable service authorization, service delivery plan, documentation, training, supervision, evaluation, or other program requirements; or

(8) after receiving a lawful request for records by any state agency or law enforcement agency, intentionally destroys, or attempts or conspires to destroy, medical, health care, and financial records required to be maintained under chapter 245A or 256B or rules adopted pursuant to those chapters.

Subd. 2. **Penalties.** (a) A person who is convicted under subdivision 1 may be sentenced to imprisonment for not more than ten years or to payment of not more than $20,000, or both.

(b) A person who is convicted under subdivision 1 may be sentenced to imprisonment for not more than 20 years or to payment of not more than $100,000, or both, if the violation causes a loss to any victim in an aggregate amount of more than $100,000, but not more than $1,000,000.

(c) A person who is convicted under subdivision 1 may be sentenced to imprisonment for not more than 30 years or to payment of not more than $1,000,000, or both, if the violation causes a loss to any victim in an aggregate amount of more than $1,000,000.

Subd. 3. **Failure to keep or maintain medical assistance records.** A person who submits a claim for reimbursement, claim for payment, claim for reimbursement cost report, or rate application and knowingly and intentionally fails to maintain medical, health care, and financial records as required under chapter 245A or 256B or rules adopted pursuant to those chapters is guilty of a gross misdemeanor.

Subd. 4. **Continuing offense.** For purposes of calculating the statute of limitations identified in section 628.26, any violation of subdivision 1 or 3 is a continuing offense. Any violation of subdivision 1 or 3 extends to any act committed during the course of the scheme, conspiracy, or conduct and is within the statute of limitations identified in section 628.26 so long as any part of the continuing scheme, conspiracy, or conduct comprising a violation occurred within the identified statute of limitations.

Subd. 5. **Venue.** Notwithstanding anything to the contrary in section 627.01, a violation of this section may be prosecuted in:

(1) the county where any part of the offense occurred; or

(2) the county where the entity that received a claim for payment, claim for reimbursement, cost report, or rate application is located.

Subd. 6. **Restitution.** The court may order a person convicted of violating this section to pay restitution for any costs, expenses, or losses resulting from the crime and for costs, expenses, or losses resulting from similar conduct that was related to the offense but was not charged. The court may order restitution for similar conduct that was related to the offense if the related conduct occurred within the applicable statute of limitations and the prosecutor provides notice of intent to seek restitution for that conduct at least five business days before the sentencing hearing. The offender may challenge restitution as provided in section 611A.045, subdivision 3. A dispute as to whether restitution is for similar conduct that was related to the offense must be resolved by the court by the preponderance of the evidence. The burden of demonstrating that the court may order restitution for any cost, expense, or loss described in this subdivision is on the prosecution.

EFFECTIVE DATE. This section is effective August 1, 2026, and applies to crimes committed on or after that date.

Sec. 9. Minnesota Statutes 2024, section 609.52, subdivision 2, is amended to read:

Subd. 2. **Acts constituting theft.** (a) Whoever does any of the following commits theft and may be sentenced as provided in subdivision 3:

(1) intentionally and without claim of right takes, uses, transfers, conceals or retains possession of movable property of another without the other's consent and with intent to deprive the owner permanently of possession of the property; or

(2) with or without having a legal interest in movable property, intentionally and without consent, takes the property out of the possession of a pledgee or other person having a

superior right of possession, with intent thereby to deprive the pledgee or other person permanently of the possession of the property; or

(3) obtains for the actor or another the possession, custody, or title to property of or performance of services by a third person by intentionally deceiving the third person with a false representation which is known to be false, made with intent to defraud, and which does defraud the person to whom it is made. "False representation" includes without limitation:

(i) the issuance of a check, draft, or order for the payment of money, except a forged check as defined in section 609.631, or the delivery of property knowing that the actor is not entitled to draw upon the drawee therefor or to order the payment or delivery thereof; or

(ii) a promise made with intent not to perform. Failure to perform is not evidence of intent not to perform unless corroborated by other substantial evidence; or

~~(iii) the preparation or filing of a claim for reimbursement, a rate application, or a cost report used to establish a rate or claim for payment for medical care provided to a recipient of medical assistance under chapter 256B, which intentionally and falsely states the costs of or actual services provided by a vendor of medical care; or~~

~~(iv)~~ (iii) the preparation or filing of a claim for reimbursement for providing treatment or supplies required to be furnished to an employee under section 176.135 which intentionally and falsely states the costs of or actual treatment or supplies provided; or

~~(v)~~ (iv) the preparation or filing of a claim for reimbursement for providing treatment or supplies required to be furnished to an employee under section 176.135 for treatment or supplies that the provider knew were medically unnecessary, inappropriate, or excessive; or

(4) by swindling, whether by artifice, trick, device, or any other means, obtains property or services from another person; or

(5) intentionally commits any of the acts listed in this subdivision but with intent to exercise temporary control only and:

(i) the control exercised manifests an indifference to the rights of the owner or the restoration of the property to the owner; or

(ii) the actor pledges or otherwise attempts to subject the property to an adverse claim; or

(iii) the actor intends to restore the property only on condition that the owner pay a reward or buy back or make other compensation; or

(6) finds lost property and, knowing or having reasonable means of ascertaining the true owner, appropriates it to the finder's own use or to that of another not entitled thereto without first having made reasonable effort to find the owner and offer and surrender the property to the owner; or

(7) intentionally obtains property or services, offered upon the deposit of a sum of money or tokens in a coin or token operated machine or other receptacle, without making the required deposit or otherwise obtaining the consent of the owner; or

(8) intentionally and without claim of right converts any article representing a trade secret, knowing it to be such, to the actor's own use or that of another person or makes a copy of an article representing a trade secret, knowing it to be such, and intentionally and without claim of right converts the same to the actor's own use or that of another person. It shall be a complete defense to any prosecution under this clause for the defendant to show that information comprising the trade secret was rightfully known or available to the defendant from a source other than the owner of the trade secret; or

(9) leases or rents personal property under a written instrument and who:

(i) with intent to place the property beyond the control of the lessor conceals or aids or abets the concealment of the property or any part thereof; or

(ii) sells, conveys, or encumbers the property or any part thereof without the written consent of the lessor, without informing the person to whom the lessee sells, conveys, or encumbers that the same is subject to such lease or rental contract with intent to deprive the lessor of possession thereof; or

(iii) does not return the property to the lessor at the end of the lease or rental term, plus agreed-upon extensions, with intent to wrongfully deprive the lessor of possession of the property; or

(iv) returns the property to the lessor at the end of the lease or rental term, plus agreed-upon extensions, but does not pay the lease or rental charges agreed upon in the written instrument, with intent to wrongfully deprive the lessor of the agreed-upon charges.

For the purposes of items (iii) and (iv), the value of the property must be at least $100.

Evidence that a lessee used a false, fictitious, or not current name, address, or place of employment in obtaining the property or fails or refuses to return the property or pay the rental contract charges to lessor within five days after written demand for the return has

been served personally in the manner provided for service of process of a civil action or sent by certified mail to the last known address of the lessee, whichever shall occur later, shall be evidence of intent to violate this clause. Service by certified mail shall be deemed to be complete upon deposit in the United States mail of such demand, postpaid and addressed to the person at the address for the person set forth in the lease or rental agreement, or, in the absence of the address, to the person's last known place of residence; or

(10) alters, removes, or obliterates numbers or symbols placed on movable property for purpose of identification by the owner or person who has legal custody or right to possession thereof with the intent to prevent identification, if the person who alters, removes, or obliterates the numbers or symbols is not the owner and does not have the permission of the owner to make the alteration, removal, or obliteration; or

(11) with the intent to prevent the identification of property involved, so as to deprive the rightful owner of possession thereof, alters or removes any permanent serial number, permanent distinguishing number or manufacturer's identification number on personal property or possesses, sells or buys any personal property knowing or having reason to know that the permanent serial number, permanent distinguishing number or manufacturer's identification number has been removed or altered; or

(12) intentionally deprives another of a lawful charge for cable television service by:

(i) making or using or attempting to make or use an unauthorized external connection outside the individual dwelling unit whether physical, electrical, acoustical, inductive, or other connection; or by

(ii) attaching any unauthorized device to any cable, wire, microwave, or other component of a licensed cable communications system as defined in chapter 238. Nothing herein shall be construed to prohibit the electronic video rerecording of program material transmitted on the cable communications system by a subscriber for fair use as defined by Public Law 94-553, section 107; or

(13) except as provided in clauses (12) and (14), obtains the services of another with the intention of receiving those services without making the agreed or reasonably expected payment of money or other consideration; or

(14) intentionally deprives another of a lawful charge for telecommunications service by:

(i) making, using, or attempting to make or use an unauthorized connection whether physical, electrical, by wire, microwave, radio, or other means to a component of a local telecommunication system as provided in chapter 237; or

(ii) attaching an unauthorized device to a cable, wire, microwave, radio, or other component of a local telecommunication system as provided in chapter 237.

The existence of an unauthorized connection is prima facie evidence that the occupier of the premises:

(A) made or was aware of the connection; and

(B) was aware that the connection was unauthorized;

(15) with intent to defraud, diverts corporate property other than in accordance with general business purposes or for purposes other than those specified in the corporation's articles of incorporation; or

(16) with intent to defraud, authorizes or causes a corporation to make a distribution in violation of section 302A.551, or any other state law in conformity with it; or

(17) takes or drives a motor vehicle without the consent of the owner or an authorized agent of the owner, knowing or having reason to know that the owner or an authorized agent of the owner did not give consent; or

(18) intentionally, and without claim of right, takes motor fuel from a retailer without the retailer's consent and with intent to deprive the retailer permanently of possession of the fuel by driving a motor vehicle from the premises of the retailer without having paid for the fuel dispensed into the vehicle; or

(19) commits wage theft under subdivision 1, clause (13).

(b) Proof that the driver of a motor vehicle into which motor fuel was dispensed drove the vehicle from the premises of the retailer without having paid for the fuel permits the factfinder to infer that the driver acted intentionally and without claim of right, and that the driver intended to deprive the retailer permanently of possession of the fuel. This paragraph does not apply if: (1) payment has been made to the retailer within 30 days of the receipt of notice of nonpayment under section 604.15; or (2) a written notice as described in section 604.15, subdivision 4, disputing the retailer's claim, has been sent. This paragraph does not apply to the owner of a motor vehicle if the vehicle or the vehicle's license plate has been reported stolen before the theft of the fuel.

EFFECTIVE DATE. This section is effective August 1, 2026, and applies to crimes committed on or after that date.

Sec. 10. Minnesota Statutes 2025 Supplement, section 609.902, subdivision 4, is amended to read:

Subd. 4. **Criminal act.** "Criminal act" means conduct constituting, or a conspiracy or attempt to commit, a felony violation of chapter 152, or a felony violation of section 299F.79; 299F.80; 299F.82; 609.185; 609.19; 609.195; 609.20; 609.205; 609.221; 609.222; 609.223; 609.2231; 609.228; 609.235; 609.245; 609.25; 609.27; 609.322; 609.342; 609.343; 609.344; 609.345; 609.42; 609.467; 609.48; 609.485; 609.495; 609.496; 609.497; 609.498; 609.52, subdivision 2, if the offense is punishable under subdivision 3, clause (1), if the property is a firearm, clause (3)(b), or clause (3)(d)(v); section 609.52, subdivision 2, paragraph (a), clause (1) or (4); 609.527, if the crime is punishable under subdivision 3, clause (4); 609.528, if the crime is punishable under subdivision 3, clause (4); 609.53; 609.561; 609.562; 609.582, subdivision 1 or 2; 609.668, subdivision 6, paragraph (a); 609.67; 609.687; 609.713; 609.86; 609.894, subdivision 3 or 4; 609.895; 624.713; 624.7191; or 626A.02, subdivision 1, if the offense is punishable under section 626A.02, subdivision 4, paragraph (a). "Criminal act" also includes conduct constituting, or a conspiracy or attempt to commit, a felony violation of section 609.52, subdivision 2, clause (3), (4), (15), or (16), if the violation involves an insurance company as defined in section 60A.02, subdivision 4, a nonprofit health service plan corporation regulated under chapter 62C, a health maintenance organization regulated under chapter 62D, ~~or~~ a fraternal benefit society regulated under chapter 64B, or any state agency.

Sec. 11. Minnesota Statutes 2025 Supplement, section 628.26, is amended to read:

628.26 LIMITATIONS.

(a) Indictments or complaints for any crime resulting in the death of the victim may be found or made at any time after the death of the person killed.

(b) Indictments or complaints for a violation of section 609.25 may be found or made at any time after the commission of the offense.

(c) Indictments or complaints for violation of section 609.282 may be found or made at any time after the commission of the offense if the victim was under the age of 18 at the time of the offense.

(d) Indictments or complaints for violation of section 609.282 where the victim was 18 years of age or older at the time of the offense, or 609.42, subdivision 1, clause (1) or (2), shall be found or made and filed in the proper court within six years after the commission of the offense.

(e) Indictments or complaints for violation of sections 609.322, 609.342 to 609.345, and 609.3458 may be found or made at any time after the commission of the offense.

(f) Indictments or complaints for a violation of section 609.561 shall be found or made and filed in the proper court within ten years after the commission of the offense.

(g) Indictments or complaints for violation of sections ~~609.466~~ 609.467 and 609.52, subdivision 2, paragraph (a), clause (3), item (iii), shall be found or made and filed in the proper court within six years after the commission of the offense.

(h) Indictments or complaints for violation of section 609.2335, 609.52, subdivision 2, paragraph (a), clause (3), items (i) and (ii), (4), (15), or (16), 609.631, or 609.821, where the value of the property or services stolen is more than $35,000, or for violation of section 609.527 where the offense involves eight or more direct victims or the total combined loss to the direct and indirect victims is more than $35,000, shall be found or made and filed in the proper court within five years after the commission of the offense.

(i) Except for violations relating to false material statements, representations or omissions, indictments or complaints for violations of section 609.671 shall be found or made and filed in the proper court within five years after the commission of the offense.

(j) Indictments or complaints for violation of sections 609.562 and 609.563, shall be found or made and filed in the proper court within five years after the commission of the offense.

(k) Indictments or complaints for violation of section 609.746 shall be found or made and filed in the proper court within the later of three years after the commission of the offense or three years after the offense was reported to law enforcement authorities.

(l) In all other cases, indictments or complaints shall be found or made and filed in the proper court within three years after the commission of the offense.

(m) The limitations periods contained in this section shall exclude any period of time during which the defendant was not an inhabitant of or usually resident within this state.

(n) The limitations periods contained in this section for an offense shall not include any period during which the alleged offender participated under a written agreement in a pretrial diversion program relating to that offense.

(o) The limitations periods contained in this section shall not include any period of time during which physical evidence relating to the offense was undergoing DNA analysis, as defined in section 299C.155, unless the defendant demonstrates that the prosecuting or law enforcement agency purposefully delayed the DNA analysis process in order to gain an unfair advantage.

Sec. 12. **DIRECTION TO COMMISSIONER; ASSESSMENT OF ADMINISTRATION ROLES.**

(a) The commissioner of human services, in consultation with Tribal Nations and counties, must conduct a study to assess and recommend improvements to the roles and responsibilities of the state agency, counties, and Tribal Nations in administering human services programs.

(b) The study must include a comprehensive review of programs administered by the department, including but not limited to medical assistance, MinnesotaCare, behavioral health services, long-term services and supports, housing and homelessness programs, Minnesota supplemental aid, general assistance, and licensing and oversight functions.

(c) The study must evaluate the:

(1) current roles and responsibilities held by the state agency, counties, and Tribal Nations in administering human services programs, including but not limited to the challenges and benefits of the current delegation of roles and responsibilities;

(2) lived experience of people accessing human services programs related to the delegation of administrative duties;

(3) financing of human services program administration across the state agency, counties, and Tribal Nations;

(4) variations in service delivery between different geographical regions of the state; and

(5) administration of human services programs in other states, focusing on the roles and responsibilities of the local governments versus the state Medicaid or human services agency, and identifying the benefits, challenges, and financing of the delegation of duties.

(d) The study must focus on the goals of transforming the human services system to ensure a transparent, accessible, accountable, equitable, and effective human services system.

(e) The study must provide recommendations for the optimal delegation of duties between the state agency, counties, and Tribal Nations in the delivery of human services. Recommendations must include:

(1) how the delegation of duties will improve the experience of people accessing human services;

(2) implementation and timing considerations to ensure continuity of services;

(3) systems technology adaptations required;

(4) workforce considerations; and

(5) financing strategies and the estimated fiscal impact to the state budget.

(f) By October 1, 2028, the commissioner must submit a report on the study and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 13. **REPEALER.**

Minnesota Statutes 2024, section 609.466, is repealed.

ARTICLE 8

DEPARTMENT OF HUMAN SERVICES APPROPRIATIONS

Section 1. **HUMAN SERVICES APPROPRIATIONS.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2025, First Special Session chapter 9, article 12, from the general fund or any fund named for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal years ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **TOTAL APPROPRIATION**	**$ -0-**	**$ (122,988,000)**

Appropriations by Fund

	2026	2027
General	-0-	(125,001,000)
Special Government Revenue Fund	-0-	2,013,000

Sec. 3. **CENTRAL OFFICE; OPERATIONS** **$ -0- $ 28,615,000**

Subdivision 1. **Evaluation of DHS Structure and Processes**

$500,000 in fiscal year 2027 is for a comprehensive evaluation of the Department of Human Services structure and processes. This is a onetime appropriation and is available until June 30, 2028.

Subd. 2. **Assessment of State, County, and Tribal Nation Roles in Administering Human Services Programs**

$3,000,000 in fiscal year 2027 is for an assessment of state, county, and Tribal Nation roles in administering human services programs. This is a onetime appropriation and is available until June 30, 2029.

Subd. 3. **Base Level Adjustment**

The general fund base is increased by $19,071,000 in fiscal year 2028 and increased by $16,954,000 in fiscal year 2029.

Sec. 4. **CENTRAL OFFICE; HEALTH CARE** **$ -0- $ 1,795,000**

Base Level Adjustment The general fund base is increased by $2,195,000 in fiscal year 2028 and increased by $2,160,000 in fiscal year 2029.

Sec. 5. **CENTRAL OFFICE; AGING AND DISABILITY SERVICES** **$ -0- $ 16,977,000**

Subdivision 1. **Market Rate and Homemaker Services Rate Study**

$500,000 in fiscal year 2027 is for a study on rate setting methodologies for services currently offered under market rate methodologies and homemaker services. This is onetime appropriation and is available until June 30, 2028.

Subd. 2. **Waiver Case Management Study**

$300,000 in fiscal year 2027 is for a study on waiver case management services. This is a onetime appropriation and is available until June 30, 2028.

Subd. 3. **Base Level Adjustment**

The general fund base is increased by $27,758,000 in fiscal year 2028 and increased by $28,498,000 in fiscal year 2029.

Sec. 6. **CENTRAL OFFICE; BEHAVIORAL HEALTH** **$** **-0-** **$** **1,634,000**

Subdivision 1. **Access to Services for Incarcerated Individuals Evaluation**

$150,000 in fiscal year 2027 is for community engagement and evaluation related reentry services.

Subd. 2. **Base Level Adjustment**

The general fund base is increased by $2,094,000 in fiscal year 2028 and increased by $2,077,000 in fiscal year 2029.

Sec. 7. **CENTRAL OFFICE; OFFICE OF INSPECTOR GENERAL** **$** **-0-** **$** **39,695,000**

Subdivision 1. **Appropriations by Fund**

Appropriations by Fund		
	2026	2027
General Fund	-0-	37,682,000
Special Government Revenue Fund	-0-	2,013,000

Subd. 2. **Base Level Adjustment**

The general fund base is increased by $38,431,000 in fiscal year 2028 and increased by $38,431,000 in fiscal year 2029. The special revenue government fund base is increased by $2,352,000 in fiscal year 2028

and increased by $2,352,000 in fiscal year 2029.

Sec. 8. **FORECASTED PROGRAMS; HOUSING SUPPORT** **$ -0- $ 10,057,000**

Sec. 9. **FORECASTED PROGRAMS; MEDICAL ASSISTANCE** **$ -0- $ (202,368,000)**

Sec. 10. **FORECASTED PROGRAMS; ALTERNATIVE CARE** **$ -0- $ (156,000)**

Sec. 11. **FORECASTED PROGRAMS; BEHAVIORAL HEALTH FUND** **$ -0- $ (19,237,000)**

ARTICLE 9

OTHER AGENCY APPROPRIATIONS

Section 1. **OTHER AGENCY APPROPRIATIONS.**

The dollar amounts shown in the columns marked "Appropriations" are added to or, if shown in parentheses, are subtracted from the appropriations in Laws 2025, First Special Session chapter 9, article 14, from the general fund or any fund named for the purposes specified in this article, to be available for the fiscal year indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal years ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **ATTORNEY GENERAL**	**$ -0-**	**$ 1,230,000**

$1,230,000 in fiscal year 2027 is for the Medicaid Fraud Unit. This is a onetime appropriation.

Sec. 3. **DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES**

Subdivision 1. **Operations and Administration: Agency-wide Supports** **$ -0- $ 3,304,000**

Subd. 2. **Assessment of State, County, and Tribal Nation Roles in Administering Human Services Programs**

$2,500,000 in fiscal year 2027 is for an assessment of state, county, and Tribal Nation roles in administering human services programs. This is a onetime appropriation and is available until June 30, 2029.

APPENDIX
Article locations for H4338-1

245.735 CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC SERVICES.

Subd. 1a. **Definitions.** (a) For the purposes of this section, the terms in this subdivision have the meanings given.

(b) "Alcohol and drug counselor" has the meaning given in section 245G.11, subdivision 5.

(c) "Care coordination" means the activities required to coordinate care across settings and providers for a person served to ensure seamless transitions across the full spectrum of health services. Care coordination includes outreach and engagement; documenting a plan of care for medical, behavioral health, and social services and supports in the integrated treatment plan; assisting with obtaining appointments; confirming appointments are kept; developing a crisis plan; tracking medication; and implementing care coordination agreements with external providers. Care coordination may include psychiatric consultation with primary care practitioners and with mental health clinical care practitioners.

(d) "Community needs assessment" means an assessment to identify community needs and determine the community behavioral health clinic's capacity to address the needs of the population being served.

(e) "Comprehensive evaluation" means a person-centered, family-centered, and trauma-informed evaluation meeting the requirements of subdivision 4b completed for the purposes of diagnosis and treatment planning.

(f) "Designated collaborating organization" means an entity meeting the requirements of subdivision 3a with a formal agreement with a CCBHC to furnish CCBHC services.

(g) "Functional assessment" means an assessment of a client's current level of functioning relative to functioning that is appropriate for someone the client's age and that meets the requirements of subdivision 4a.

(h) "Initial evaluation" means an evaluation completed by a mental health professional that gathers and documents information necessary to formulate a preliminary diagnosis and begin client services.

(i) "Integrated treatment plan" means a documented plan of care that is person- and family-centered and formulated to respond to a client's needs and goals.

(j) "Mental health professional" has the meaning given in section 245I.04, subdivision 2.

(k) "Mobile crisis services" has the meaning given in section 256B.0624, subdivision 2.

(l) "Preliminary screening and risk assessment" means a mandatory screening and risk assessment that is completed at the first contact with the prospective CCBHC service recipient and determines the acuity of client need.

Subd. 2a. **Establishment.** The certified community behavioral health clinic model is an integrated payment and service delivery model that uses evidence-based behavioral health practices to achieve better outcomes for individuals experiencing behavioral health concerns while achieving sustainable rates for providers and economic efficiencies for payors.

Subd. 3. **Certified community behavioral health clinics.** (a) The commissioner shall establish state certification and recertification processes for certified community behavioral health clinics (CCBHCs) that satisfy all federal requirements necessary for CCBHCs certified under this section to be eligible for reimbursement under medical assistance, without service area limits based on geographic area or region. The commissioner shall consult with CCBHC stakeholders before establishing and implementing changes in the certification or recertification process and requirements. Any changes to the certification or recertification process or requirements must be consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration. The commissioner must allow a transition period for CCBHCs to meet the revised criteria on or before January 1, 2025. The commissioner is authorized to amend the state's Medicaid state plan or the terms of the demonstration to comply with federal requirements.

(b) As part of the state CCBHC certification and recertification processes, the commissioner shall provide to entities applying for certification or requesting recertification the standard requirements of the community needs assessment and the staffing plan that are consistent with the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(c) The commissioner shall schedule a certification review that includes a site visit within 90 calendar days of receipt of an application for certification or recertification.

(d) Entities that choose to be CCBHCs must:

(1) complete a community needs assessment and complete a staffing plan that is responsive to the needs identified in the community needs assessment and update both the community needs assessment and the staffing plan no less frequently than every 36 months;

(2) comply with state licensing requirements and other requirements issued by the commissioner;

(3) employ or contract with a medical director. A medical director must be a physician licensed under chapter 147 and either certified by the American Board of Psychiatry and Neurology, certified by the American Osteopathic Board of Neurology and Psychiatry, or eligible for board certification in psychiatry. A registered nurse who is licensed under sections 148.171 to 148.285 and is certified as a nurse practitioner in adult or family psychiatric and mental health nursing by a national nurse certification organization may serve as the medical director when a CCBHC is unable to employ or contract a qualified physician;

(4) employ or contract for clinic staff who have backgrounds in diverse disciplines, including licensed mental health professionals and licensed alcohol and drug counselors, and staff who are culturally and linguistically trained to meet the needs of the population the clinic serves;

(5) ensure that clinic services are available and accessible to individuals and families of all ages and genders with access on evenings and weekends and that crisis management services are available 24 hours per day;

(6) establish fees for clinic services for individuals who are not enrolled in medical assistance using a sliding fee scale that ensures that services to patients are not denied or limited due to an individual's inability to pay for services;

(7) comply with quality assurance reporting requirements and other reporting requirements included in the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration;

(8) provide crisis mental health and substance use services, withdrawal management services, emergency crisis intervention services, and stabilization services through existing mobile crisis services; screening, assessment, and diagnosis services, including risk assessments and level of care determinations; person- and family-centered treatment planning; outpatient mental health and substance use services; targeted case management; psychiatric rehabilitation services; peer support and counselor services and family support services; and intensive community-based mental health services, including mental health services for members of the armed forces and veterans. CCBHCs must directly provide the majority of these services to enrollees, but may coordinate some services with another entity through a collaboration or agreement, pursuant to subdivision 3a;

(9) provide coordination of care across settings and providers to ensure seamless transitions for individuals being served across the full spectrum of health services, including acute, chronic, and behavioral needs;

(10) be certified as a mental health clinic under section 245I.20;

(11) comply with standards established by the commissioner relating to CCBHC screenings, assessments, and evaluations that are consistent with this section;

(12) be licensed to provide substance use disorder treatment under chapter 245G;

(13) be certified to provide children's therapeutic services and supports under section 256B.0943;

(14) be certified to provide adult rehabilitative mental health services under section 256B.0623;

(15) be enrolled to provide mental health crisis response services under section 256B.0624;

(16) be enrolled to provide mental health targeted case management under section 256B.0625, subdivision 20;

(17) provide services that comply with the evidence-based practices described in subdivision 3d;

(18) provide peer services as defined in sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph (b), clause (2), as applicable when peer services are provided; and

(19) inform all clients upon initiation of care of the full array of services available under the CCBHC model.

Subd. 3a. **Designated collaborating organizations.** If a certified CCBHC is unable to provide one or more of the services listed in subdivision 3, paragraph (d), clauses (8) to (19), the CCBHC may contract with another entity that has the required authority to provide that service and that meets the requirements of the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

Subd. 3b. **Exemptions to host county approval.** Notwithstanding any other law that requires a county contract or other form of county approval for a service listed in subdivision 3, paragraph (d), clause (8), a CCBHC that meets the requirements of this section may receive the prospective payment under section 256B.0625, subdivision 5m, for that service without a county contract or county approval.

Subd. 3c. **Variances.** When the standards listed in this section or other applicable standards conflict or address similar issues in duplicative or incompatible ways, the commissioner may grant variances to state requirements if the variances do not conflict with federal requirements for services reimbursed under medical assistance. If standards overlap, the commissioner may substitute all or a part of a licensure or certification that is substantially the same as another licensure or certification. The commissioner shall consult with stakeholders before granting variances under this provision. For a CCBHC that is certified but not approved for prospective payment under section 256B.0625, subdivision 5m, the commissioner may grant a variance under this paragraph if the variance does not increase the state share of costs.

Subd. 3d. **Evidence-based practices.** The commissioner shall issue a list of required evidence-based practices to be delivered by CCBHCs and may also provide a list of recommended evidence-based practices. The commissioner may update the list to reflect advances in outcomes research and medical services for persons living with mental illnesses or substance use disorders. The commissioner shall take into consideration the adequacy of evidence to support the efficacy of the practice across cultures and ages, the workforce available, and the current availability of the practice in the state. At least 30 days before issuing the initial list or issuing any revisions, the commissioner shall provide stakeholders with an opportunity to comment.

Subd. 3e. **Recertification.** A CCBHC must apply for recertification every 36 months.

Subd. 3f. **Notice and opportunity for correction.** (a) The commissioner shall provide a formal written notice to an applicant for CCBHC certification outlining the determination of the application and process for applicable and necessary corrective action required of the applicant signed by the commissioner or appropriate division director to applicant entities within 45 calendar days of the site visit.

(b) The commissioner may reject an application if the applicant entity does not take all corrective actions specified in the notice and notify the commissioner that the applicant entity has done so within 60 calendar days.

(c) The commissioner must send the applicant entity a final decision on the corrected application within 45 calendar days of the applicant entity's notice to the commissioner that the applicant has taken the required corrective actions.

Subd. 3g. **Decertification process.** The commissioner must establish a process for decertification. The commissioner must require corrective action, medical assistance repayment, or decertification of a CCBHC that no longer meets the requirements in this section or that fails to meet the standards provided by the commissioner in the application, certification, or recertification process.

Subd. 3h. **Minimum staffing standards.** A CCBHC must meet minimum staffing requirements required by the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

Subd. 4a. **Functional assessment requirements.** (a) For adults, a functional assessment may be completed using a Daily Living Activities-20 tool.

(b) Notwithstanding any law to the contrary, a functional assessment performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 256B.0623, subdivision 9;

(2) section 245.4711, subdivision 3; and

(3) Minnesota Rules, part 9520.0914, subpart 2.

Subd. 4b. **Requirements for comprehensive evaluations.** (a) A comprehensive evaluation must be completed for all new clients within 60 calendar days following the preliminary screening and risk assessment.

(b) Only a mental health professional may complete a comprehensive evaluation. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate.

(c) The comprehensive evaluation must consist of the synthesis of existing information including but not limited to an external diagnostic assessment, crisis assessment, preliminary screening and risk assessment, initial evaluation, and primary care screenings.

(d) A comprehensive evaluation must be completed in the cultural context of the client and updated to reflect changes in the client's conditions and at the client's request or when the client's condition no longer meets the existing diagnosis.

(e) The psychiatric evaluation and management service fulfills requirements for the comprehensive evaluation when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC shall complete the comprehensive evaluation within 60 calendar days of a client's referral for additional CCBHC services.

(f) For clients engaging exclusively in substance use disorder services at the CCBHC, a substance use disorder comprehensive assessment as defined in section 245G.05, subdivision 2, that is completed within 60 calendar days of service initiation shall fulfill requirements of the comprehensive evaluation.

(g) Notwithstanding any law to the contrary, a comprehensive evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 245.462, subdivision 20, paragraph (c);

(2) section 245.4711, subdivision 2, paragraph (b);

(3) section 245.4871, subdivision 6;

(4) section 245.4881, subdivision 2, paragraph (c);

(5) section 245G.04, subdivision 1;

(6) section 245G.05, subdivision 1;

(7) section 245I.10, subdivisions 4 to 6;

(8) section 256B.0623, subdivisions 3, clause (4), 8, and 10;

(9) section 256B.0943, subdivisions 3 and 6, paragraph (b), clause (1);

(10) Minnesota Rules, part 9520.0909, subpart 1;

(11) Minnesota Rules, part 9520.0910, subparts 1 and 2; and

(12) Minnesota Rules, part 9520.0914, subpart 2.

Subd. 4c. **Requirements for initial evaluations.** (a) A CCBHC must complete either an initial evaluation or a comprehensive evaluation as required by the most recently issued Certified Community Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental Health Services Administration.

(b) Notwithstanding any law to the contrary, an initial evaluation performed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 245.4711, subdivision 4;

(2) section 245.4881, subdivisions 3 and 4;

(3) section 245I.10, subdivision 5;

(4) section 256B.0623, subdivisions 3, clause (4), 8, and 10;

(5) section 256B.0943, subdivisions 3 and 6, paragraph (b), clauses (1) and (2);

(6) Minnesota Rules, part 9520.0909, subpart 1;

(7) Minnesota Rules, part 9520.0910, subpart 1;

(8) Minnesota Rules, part 9520.0914, subpart 2;

(9) Minnesota Rules, part 9520.0918, subparts 1 and 2; and

(10) Minnesota Rules, part 9520.0919, subpart 2.

Subd. 4d. **Requirements for integrated treatment plans.** (a) An integrated treatment plan must be completed within 60 calendar days following the preliminary screening and risk assessment and updated no less frequently than every six months or when the client's circumstances change.

(b) Only a mental health professional may complete an integrated treatment plan. The mental health professional must consult with an alcohol and drug counselor when substance use disorder services are deemed clinically appropriate. An alcohol and drug counselor may approve the integrated treatment plan. The integrated treatment plan must be developed through a shared decision-making process with the client, the client's support system if the client chooses, or, for children, with the family or caregivers.

(c) The integrated treatment plan must:

(1) use the ASAM 6 dimensional framework; and

(2) incorporate prevention, medical and behavioral health needs, and service delivery.

(d) The psychiatric evaluation and management service fulfills requirements for the integrated treatment plan when a client of a CCBHC is receiving exclusively psychiatric evaluation and management services. The CCBHC must complete an integrated treatment plan within 60 calendar days of a client's referral for additional CCBHC services.

(e) Notwithstanding any law to the contrary, an integrated treatment plan developed by a CCBHC that meets the requirements of this subdivision satisfies the requirements in:

(1) section 245G.06, subdivision 1;

(2) section 245G.09, subdivision 3, paragraph (a), clause (6);

(3) section 245I.10, subdivisions 7 and 8; and

(4) section 256B.0943, subdivision 6, paragraph (b), clause (2).

Subd. 4e. **Additional licensing and certification requirements.** (a) This subdivision applies to programs and clinics that are a part of a CCBHC.

(b) The requirements for initial evaluations under subdivision 4c, comprehensive evaluations under subdivision 4b, and integrated treatment plans under subdivision 4d are incorporated into the licensing requirements for substance use disorder treatment programs under chapter 245G.

(c) The requirements for initial evaluations under subdivision 4c, comprehensive evaluations under subdivision 4b, and integrated treatment plans under subdivision 4d are incorporated into the certification requirements for mental health clinics under section 245I.20.

(d) The Department of Human Services licensing division will review, inspect, and investigate for compliance with the requirements in subdivisions 4b to 4d for programs or clinics subject to this subdivision.

Subd. 7. **Addition of CCBHCs to section 223 state demonstration programs.** (a) If the commissioner's request under subdivision 6 to reenter the demonstration program established by section 223 of the Protecting Access to Medicare Act is approved, upon reentry the commissioner must follow all federal guidance on the addition of CCBHCs to section 223 state demonstration programs.

(b) Prior to participating in the demonstration, a CCBHC must meet the demonstration certification criteria and prospective payment system guidance in effect at that time and be certified as a CCBHC by the state. The Substance Abuse and Mental Health Services Administration attestation process for CCBHC expansion grants is not sufficient to constitute state certification. CCBHCs newly added to the demonstration must participate in all aspects of the state demonstration program, including but not limited to quality measurement and reporting, evaluation activities, and state CCBHC demonstration program requirements, such as use of state-specified evidence-based practices. A newly added CCBHC must report on quality measures before its first full demonstration year if it joined the demonstration program in calendar year 2023 out of alignment with the state's

demonstration year cycle. A CCBHC may provide services in multiple locations and in community-based settings subject to federal rules of the 223 demonstration authority or Medicaid state plan authority.

(c) If a CCBHC meets the definition of a satellite facility, as defined by the Substance Abuse and Mental Health Services Administration, and was established after April 1, 2014, the CCBHC cannot receive payment as a part of the demonstration program.

Subd. 8. **Grievance procedures required.** CCBHCs and designated collaborating organizations must allow all service recipients access to grievance procedures, which must satisfy the minimum requirements of medical assistance and other grievance requirements such as those that may be mandated by relevant accrediting entities.

245A.10 FEES.

Subd. 3a. **Fee for change of ownership exception.** (a) A license holder must submit a fee of $2,100 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(b) License holders under chapter 245D must submit a fee of $4,200 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

(c) A license holder for a children's residential facility must submit a fee of $500 for each license subject to the change in ownership exception under section 245A.043, subdivision 2, paragraph (b).

245C.03 BACKGROUND STUDY; INDIVIDUALS TO BE STUDIED.

Subd. 7. **Children's therapeutic services and supports providers.** The commissioner shall conduct background studies of all direct service providers and volunteers for children's therapeutic services and supports providers under section 256B.0943.

245I.20 MENTAL HEALTH CLINIC.

Subd. 9. **Quality assurance and improvement plan.** (a) At a minimum, a certification holder must develop a written quality assurance and improvement plan that includes a plan for:

(1) encouraging ongoing consultation among members of the treatment team;

(2) obtaining and evaluating feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measuring and evaluating client outcomes;

(4) reviewing client suicide deaths and suicide attempts;

(5) examining the quality of clinical service delivery to clients; and

(6) self-monitoring of compliance with this chapter.

(b) At least annually, the certification holder must review, evaluate, and update the quality assurance and improvement plan. The review must: (1) include documentation of the actions that the certification holder will take as a result of information obtained from monitoring activities in the plan; and (2) establish goals for improved service delivery to clients for the next year.

245I.23 INTENSIVE RESIDENTIAL TREATMENT SERVICES AND RESIDENTIAL CRISIS STABILIZATION.

Subd. 23. **Quality assurance and improvement plan.** (a) A license holder must develop a written quality assurance and improvement plan that includes a plan to:

(1) encourage ongoing consultation between members of the treatment team;

(2) obtain and evaluate feedback about services from clients, family and other natural supports, referral sources, and staff persons;

(3) measure and evaluate client outcomes in the program;

(4) review critical incidents in the program;

(5) examine the quality of clinical services in the program; and

(6) self-monitor the license holder's compliance with this chapter.

(b) At least annually, the license holder must review, evaluate, and update the license holder's quality assurance and improvement plan. The license holder's review must:

(1) document the actions that the license holder will take in response to the information that the license holder obtains from the monitoring activities in the plan; and

(2) establish goals for improving the license holder's services to clients during the next year.

256B.055 ELIGIBILITY CATEGORIES.

Subd. 14. **Persons detained by law.** (a) Medical assistance may be paid for an inmate of a correctional facility who is conditionally released as authorized under section 241.26, 244.065, or 631.425, if the individual does not require the security of a public detention facility and is housed in a halfway house or community correction center, or under house arrest and monitored by electronic surveillance in a residence approved by the commissioner of corrections, and if the individual meets the other eligibility requirements of this chapter.

(b) An individual who is enrolled in medical assistance, and who is charged with a crime and incarcerated for less than 12 months shall be suspended from eligibility at the time of incarceration until the individual is released. Upon release, medical assistance eligibility is reinstated without reapplication using a reinstatement process and form, if the individual is otherwise eligible.

(c) An individual, regardless of age, who is considered an inmate of a public institution as defined in Code of Federal Regulations, title 42, section 435.1010, and who meets the eligibility requirements in section 256B.056, is not eligible for medical assistance, except for covered services received while an inpatient in a medical institution as defined in Code of Federal Regulations, title 42, section 435.1010. Security issues, including costs, related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate.

256B.0623 ADULT REHABILITATIVE MENTAL HEALTH SERVICES COVERED.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Adult rehabilitative mental health services" means the services described in section 245I.02, subdivision 33.

(b) "Medication education services" means services provided individually or in groups which focus on educating the recipient about mental illness and symptoms; the role and effects of medications in treating symptoms of mental illness; and the side effects of medications. Medication education is coordinated with medication management services and does not duplicate it. Medication education services are provided by physicians, advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

(c) "Transition to community living services" means services which maintain continuity of contact between the rehabilitation services provider and the recipient and which facilitate discharge from a hospital, residential treatment program, board and lodging facility, or nursing home. Transition to community living services are not intended to provide other areas of adult rehabilitative mental health services.

Subd. 4. **Provider entity standards.** (a) The provider entity must be certified by the state following the certification process and procedures developed by the commissioner.

(b) The certification process is a determination as to whether the entity meets the standards in this section and chapter 245I, as required in section 245I.011, subdivision 5. The certification must specify which adult rehabilitative mental health services the entity is qualified to provide.

(c) State-level recertification must occur at least every three years.

(d) The commissioner may intervene at any time and decertify providers with cause. The decertification is subject to appeal to the state. A county board may recommend that the state decertify a provider for cause.

(e) The adult rehabilitative mental health services provider entity must meet the following standards:

(1) have capacity to recruit, hire, manage, and train qualified staff;

(2) have adequate administrative ability to ensure availability of services;

(3) ensure that staff are skilled in the delivery of the specific adult rehabilitative mental health services provided to the individual eligible recipient;

(4) ensure enough flexibility in service delivery to respond to the changing and intermittent care needs of a recipient as identified by the recipient and the individual treatment plan;

(5) assist the recipient in arranging needed crisis assessment, intervention, and stabilization services;

(6) ensure that services are coordinated with other recipient mental health services providers and the county mental health authority and the federally recognized American Indian authority and necessary others after obtaining the consent of the recipient. Services must also be coordinated with the recipient's case manager or care coordinator if the recipient is receiving case management or care coordination services;

(7) keep all necessary records required by law;

(8) deliver services as required by section 245.461;

(9) be an enrolled Medicaid provider; and

(10) maintain a quality assurance plan to determine specific service outcomes and the recipient's satisfaction with services.

Subd. 5. **Qualifications of provider staff.** Adult rehabilitative mental health services must be provided by qualified individual provider staff of a certified provider entity. Individual provider staff must be qualified as:

(1) a mental health professional who is qualified according to section 245I.04, subdivision 2;

(2) a certified rehabilitation specialist who is qualified according to section 245I.04, subdivision 8;

(3) a clinical trainee who is qualified according to section 245I.04, subdivision 6;

(4) a mental health practitioner qualified according to section 245I.04, subdivision 4;

(5) a mental health certified peer specialist who is qualified according to section 245I.04, subdivision 10;

(6) a mental health rehabilitation worker who is qualified according to section 245I.04, subdivision 14; or

(7) a licensed occupational therapist, as defined in section 148.6402, subdivision 14.

Subd. 6. **Required supervision.** (a) A treatment supervisor providing treatment supervision required by section 245I.06 must:

(1) meet with staff receiving treatment supervision at least monthly to discuss treatment topics of interest and treatment plans of recipients; and

(2) meet at least monthly with the directing clinical trainee or mental health practitioner, if there is one, to review needs of the adult rehabilitative mental health services program, review staff on-site observations and evaluate mental health rehabilitation workers, plan staff training, review program evaluation and development, and consult with the directing clinical trainee or mental health practitioner.

(b) An adult rehabilitative mental health services provider entity must have a treatment director who is a mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The treatment director must:

(1) ensure the direct observation of mental health rehabilitation workers required by section 245I.06, subdivision 3, is provided;

(2) ensure immediate availability by phone or in person for consultation by a mental health professional, certified rehabilitation specialist, clinical trainee, or a mental health practitioner to the mental health rehabilitation worker during service provision;

(3) model service practices which: respect the recipient, include the recipient in planning and implementation of the individual treatment plan, recognize the recipient's strengths, collaborate and coordinate with other involved parties and providers;

(4) ensure that clinical trainees, mental health practitioners, and mental health rehabilitation workers are able to effectively communicate with the recipients, significant others, and providers; and

(5) oversee the record of the results of direct observation, progress note evaluation, and corrective actions taken to modify the work of the clinical trainees, mental health practitioners, and mental health rehabilitation workers.

(c) A clinical trainee or mental health practitioner who is providing treatment direction for a provider entity must receive treatment supervision at least monthly to:

(1) identify and plan for general needs of the recipient population served;

(2) identify and plan to address provider entity program needs and effectiveness;

(3) identify and plan provider entity staff training and personnel needs and issues; and

(4) plan, implement, and evaluate provider entity quality improvement programs.

Subd. 9. **Functional assessment.** (a) Providers of adult rehabilitative mental health services must complete a written functional assessment according to section 245I.10, subdivision 9, for each recipient.

(b) When a provider of adult rehabilitative mental health services completes a written functional assessment, the provider must also complete a level of care assessment as defined in section 245I.02, subdivision 19, for the recipient.

256B.0624 CRISIS RESPONSE SERVICES COVERED.

Subd. 2. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Certified rehabilitation specialist" means a staff person who is qualified under section 245I.04, subdivision 8.

(b) "Clinical trainee" means a staff person who is qualified under section 245I.04, subdivision 6.

(c) "Crisis assessment" means an immediate face-to-face assessment by a physician, a mental health professional, or a qualified member of a crisis team, as described in subdivision 6a.

(d) "Crisis intervention" means face-to-face, short-term intensive mental health services initiated during a mental health crisis to help the recipient cope with immediate stressors, identify and utilize available resources and strengths, engage in voluntary treatment, and begin to return to the recipient's baseline level of functioning.

(e) "Crisis screening" means a screening of a client's potential mental health crisis situation under subdivision 6.

(f) "Crisis stabilization" means individualized mental health services provided to a recipient that are designed to restore the recipient to the recipient's prior functional level. Crisis stabilization services may be provided in the recipient's home, the home of a family member or friend of the recipient, another community setting, a short-term supervised, licensed residential program, or an emergency department. Crisis stabilization services includes family psychoeducation.

(g) "Crisis team" means the staff of a provider entity who are supervised and prepared to provide mobile crisis services to a client in a potential mental health crisis situation.

(h) "Mental health certified family peer specialist" means a staff person who is qualified under section 245I.04, subdivision 12.

(i) "Mental health certified peer specialist" means a staff person who is qualified under section 245I.04, subdivision 10.

(j) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without the provision of crisis response services, would likely result in significantly reducing the recipient's levels of functioning in primary activities of daily living, in an emergency situation under section 62Q.55, or in the placement of the recipient in a more restrictive setting, including but not limited to inpatient hospitalization.

(k) "Mental health practitioner" means a staff person who is qualified under section 245I.04, subdivision 4.

(l) "Mental health professional" means a staff person who is qualified under section 245I.04, subdivision 2.

(m) "Mental health rehabilitation worker" means a staff person who is qualified under section 245I.04, subdivision 14.

(n) "Mobile crisis services" means screening, assessment, intervention, and community-based stabilization, excluding residential crisis stabilization, that is provided to a recipient.

Subd. 3. **Eligibility.** (a) A recipient is eligible for crisis assessment services when the recipient has screened positive for a potential mental health crisis during a crisis screening.

(b) A recipient is eligible for crisis intervention services and crisis stabilization services when the recipient has been assessed during a crisis assessment to be experiencing a mental health crisis.

Subd. 4a. **Alternative provider standards.** If a county or Tribe demonstrates that, due to geographic or other barriers, it is not feasible to provide mobile crisis intervention services according to the standards in subdivision 4, paragraph (b), the commissioner may approve an alternative plan proposed by a county or Tribe. The alternative plan must:

(1) result in increased access and a reduction in disparities in the availability of mobile crisis services;

(2) provide mobile crisis services outside of the usual nine-to-five office hours and on weekends and holidays; and

(3) comply with standards for emergency mental health services in section 245.469.

Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Qualified individual staff of a qualified provider entity must provide crisis assessment and intervention services to a recipient. A staff member providing crisis assessment and intervention services to a recipient must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health certified peer specialist.

(b) When crisis assessment and intervention services are provided to a recipient in the community, a mental health professional, clinical trainee, or mental health practitioner must lead the response.

(c) The 30 hours of ongoing training required by section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce the recipient's risk of suicide and self-injurious behavior.

(d) At least six hours of the ongoing training under paragraph (c) must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

(e) Team members must be experienced in crisis assessment, crisis intervention techniques, treatment engagement strategies, working with families, and clinical decision-making under emergency conditions and have knowledge of local services and resources.

Subd. 6. **Crisis screening.** (a) The crisis screening may use the resources of emergency services as defined in section 245.469, subdivisions 1 and 2. The crisis screening must gather information, determine whether a mental health crisis situation exists, identify parties involved, and determine an appropriate response.

(b) When conducting the crisis screening of a recipient, a provider must:

(1) employ evidence-based practices to reduce the recipient's risk of suicide and self-injurious behavior;

(2) work with the recipient to establish a plan and time frame for responding to the recipient's mental health crisis, including responding to the recipient's immediate need for support by telephone or text message until the provider can respond to the recipient face-to-face;

(3) document significant factors in determining whether the recipient is experiencing a mental health crisis, including prior requests for crisis services, a recipient's recent presentation at an emergency department, known calls to 911 or law enforcement, or information from third parties with knowledge of a recipient's history or current needs;

(4) accept calls from interested third parties and consider the additional needs or potential mental health crises that the third parties may be experiencing;

(5) provide psychoeducation, including means reduction, to relevant third parties including family members or other persons living with the recipient; and

(6) consider other available services to determine which service intervention would best address the recipient's needs and circumstances.

(c) For the purposes of this section, the following situations indicate a positive screen for a potential mental health crisis and the provider must prioritize providing a face-to-face crisis assessment of the recipient, unless a provider documents specific evidence to show why this was not possible, including insufficient staffing resources, concerns for staff or recipient safety, or other clinical factors:

(1) the recipient presents at an emergency department or urgent care setting and the health care team at that location requested crisis services; or

(2) a peace officer requested crisis services for a recipient who is potentially subject to transportation under section 253B.051.

(d) A provider is not required to have direct contact with the recipient to determine that the recipient is experiencing a potential mental health crisis. A mobile crisis provider may gather relevant information about the recipient from a third party to establish the recipient's need for services and potential safety factors.

Subd. 6a. **Crisis assessment.** (a) If a recipient screens positive for a potential mental health crisis, a crisis assessment must be completed. A crisis assessment evaluates any immediate needs for which services are needed and, as time permits, the recipient's current life situation, health information, including current medications, sources of stress, mental health problems and symptoms, strengths, cultural considerations, support network, vulnerabilities, current functioning, and the recipient's preferences as communicated directly by the recipient, or as communicated in a health care directive as described in chapters 145C and 253B, the crisis treatment plan described under subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

(b) A provider must conduct a crisis assessment at the recipient's location whenever possible.

(c) Whenever possible, the assessor must attempt to include input from the recipient and the recipient's family and other natural supports to assess whether a crisis exists.

(d) A crisis assessment includes: (1) determining (i) whether the recipient is willing to voluntarily engage in treatment, or (ii) whether the recipient has an advance directive, and (2) gathering the recipient's information and history from involved family or other natural supports.

(e) A crisis assessment must include coordinated response with other health care providers if the assessment indicates that a recipient needs detoxification, withdrawal management, or medical

stabilization in addition to crisis response services. If the recipient does not need an acute level of care, a team must serve an otherwise eligible recipient who has a co-occurring substance use disorder.

(f) If, after completing a crisis assessment of a recipient, a provider refers a recipient to an intensive setting, including an emergency department, inpatient hospitalization, or residential crisis stabilization, one of the crisis team members who completed or conferred about the recipient's crisis assessment must immediately contact the referral entity and consult with the triage nurse or other staff responsible for intake at the referral entity. During the consultation, the crisis team member must convey key findings or concerns that led to the recipient's referral. Following the immediate consultation, the provider must also send written documentation upon completion. The provider must document if these releases occurred with authorization by the recipient, the recipient's legal guardian, or as allowed by section 144.293, subdivision 5.

Subd. 6b. **Crisis intervention services.** (a) If the crisis assessment determines mobile crisis intervention services are needed, the crisis intervention services must be provided promptly. As opportunity presents during the intervention, at least two members of the mobile crisis intervention team must confer directly or by telephone about the crisis assessment, crisis treatment plan, and actions taken and needed. At least one of the team members must be providing face-to-face crisis intervention services. If providing crisis intervention services, a clinical trainee or mental health practitioner must seek treatment supervision as required in subdivision 9.

(b) If a provider delivers crisis intervention services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

(c) The mobile crisis intervention team must develop a crisis treatment plan according to subdivision 11.

(d) The mobile crisis intervention team must document which crisis treatment plan goals and objectives have been met and when no further crisis intervention services are required.

(e) If the recipient's mental health crisis is stabilized, but the recipient needs a referral to other services, the team must provide referrals to these services. If the recipient has a case manager, planning for other services must be coordinated with the case manager. If the recipient is unable to follow up on the referral, the team must link the recipient to the service and follow up to ensure the recipient is receiving the service.

(f) If the recipient's mental health crisis is stabilized and the recipient does not have an advance directive, the case manager or crisis team shall offer to work with the recipient to develop one.

Subd. 7. **Crisis stabilization services.** (a) Crisis stabilization services must be provided by qualified staff of a crisis stabilization services provider entity and must meet the following standards:

(1) a crisis treatment plan must be developed that meets the criteria in subdivision 11;

(2) staff must be qualified as defined in subdivision 8;

(3) crisis stabilization services must be delivered according to the crisis treatment plan and include face-to-face contact with the recipient by qualified staff for further assessment, help with referrals, updating of the crisis treatment plan, skills training, and collaboration with other service providers in the community; and

(4) if a provider delivers crisis stabilization services while the recipient is absent, the provider must document the reason for delivering services while the recipient is absent.

(b) If crisis stabilization services are provided in a supervised, licensed residential setting that serves no more than four adult residents, and one or more individuals are present at the setting to receive residential crisis stabilization, the residential staff must include, for at least eight hours per day, at least one mental health professional, clinical trainee, certified rehabilitation specialist, or mental health practitioner. The commissioner shall establish a statewide per diem rate for crisis stabilization services provided under this paragraph to medical assistance enrollees. The rate for a provider shall not exceed the rate charged by that provider for the same service to other payers. Payment shall not be made to more than one entity for each individual for services provided under this paragraph on a given day. The commissioner shall set rates prospectively for the annual rate period. The commissioner shall require providers to submit annual cost reports on a uniform cost reporting form and shall use submitted cost reports to inform the rate-setting process. The commissioner shall recalculate the statewide per diem every year.

Subd. 8. **Crisis stabilization staff qualifications.** (a) Mental health crisis stabilization services must be provided by qualified individual staff of a qualified provider entity. A staff member providing crisis stabilization services to a recipient must be qualified as a:

(1) mental health professional;

(2) certified rehabilitation specialist;

(3) clinical trainee;

(4) mental health practitioner;

(5) mental health certified family peer specialist;

(6) mental health certified peer specialist; or

(7) mental health rehabilitation worker.

(b) The 30 hours of ongoing training required in section 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children and adults and include training about evidence-based practices identified by the commissioner of health to reduce a recipient's risk of suicide and self-injurious behavior.

(c) For providers who deliver care to children 21 years of age and younger, at least six hours of the ongoing training under this subdivision must be specific to working with families and providing crisis stabilization services to children and include the following topics:

(1) developmental tasks of childhood and adolescence;

(2) family relationships;

(3) child and youth engagement and motivation, including motivational interviewing;

(4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and queer youth;

(5) positive behavior support;

(6) crisis intervention for youth with developmental disabilities;

(7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral therapy; and

(8) youth substance use.

This paragraph does not apply to adult residential crisis stabilization service providers licensed according to section 245I.23.

Subd. 9. **Supervision.** Clinical trainees and mental health practitioners may provide crisis assessment and crisis intervention services if the following treatment supervision requirements are met:

(1) the mental health provider entity must accept full responsibility for the services provided;

(2) the mental health professional of the provider entity must be immediately available by phone or in person for treatment supervision;

(3) the mental health professional is consulted, in person or by phone, during the first three hours when a clinical trainee or mental health practitioner provides crisis assessment or crisis intervention services; and

(4) the mental health professional must:

(i) review and approve, as defined in section 245I.02, subdivision 2, of the tentative crisis assessment and crisis treatment plan within 24 hours of first providing services to the recipient, notwithstanding section 245I.08, subdivision 3; and

(ii) document the consultation required in clause (3).

Subd. 11. **Crisis treatment plan.** (a) Within 24 hours of the recipient's admission, the provider entity must complete the recipient's crisis treatment plan. The provider entity must:

(1) base the recipient's crisis treatment plan on the recipient's crisis assessment;

(2) consider crisis assistance strategies that have been effective for the recipient in the past;

(3) for a child recipient, use a child-centered, family-driven, and culturally appropriate planning process that allows the recipient's parents and guardians to observe or participate in the recipient's individual and family treatment services, assessment, and treatment planning;

(4) for an adult recipient, use a person-centered, culturally appropriate planning process that allows the recipient's family and other natural supports to observe or participate in treatment services, assessment, and treatment planning;

(5) identify the participants involved in the recipient's treatment planning. The recipient, if possible, must be a participant;

(6) identify the recipient's initial treatment goals, measurable treatment objectives, and specific interventions that the license holder will use to help the recipient engage in treatment;

(7) include documentation of referral to and scheduling of services, including specific providers where applicable;

(8) ensure that the recipient or the recipient's legal guardian approves under section 245I.02, subdivision 2, of the recipient's crisis treatment plan unless a court orders the recipient's treatment plan under chapter 253B. If the recipient or the recipient's legal guardian disagrees with the crisis treatment plan, the license holder must document in the client file the reasons why the recipient disagrees with the crisis treatment plan; and

(9) ensure that a treatment supervisor approves under section 245I.02, subdivision 2, of the recipient's treatment plan within 24 hours of the recipient's admission if a mental health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding section 245I.08, subdivision 3.

(b) The provider entity must provide the recipient and the recipient's legal guardian with a copy of the recipient's crisis treatment plan.

256B.0701 RECUPERATIVE CARE SERVICES.

Subd. 11. **Requirements for provider enrollment; compliance training.** (a) Effective January 1, 2027, to enroll as a recuperative care provider, a provider must require all owners of the provider who are active in the day-to-day management and operations of the agency and all managerial and supervisory employees to complete compliance training before applying for enrollment and every three years thereafter. Mandatory compliance training format and content must be determined by the commissioner and must include the following topics:

(1) state and federal program billing, documentation, and service delivery requirements;

(2) enrollment requirements;

(3) provider program integrity, including fraud prevention, detection, and penalties;

(4) fair labor standards;

(5) workplace safety requirements; and

(6) recent changes in service requirements.

(b) New owners active in day-to-day management and operations of the provider and new managerial and supervisory employees must complete compliance training under this subdivision to be employed by or conduct management and operations activities for the provider. If an individual moves to another recuperative care provider and serves in a similar ownership or employment capacity, the individual is not required to repeat the training required under this subdivision if the individual documents completion of the training within the past three years.

(c) Any recuperative care provider enrolled before January 1, 2027, must complete the compliance training by January 1, 2028, and every three years thereafter.

256B.073 ELECTRONIC VISIT VERIFICATION.

Subd. 4. **Provider requirements.** (a) A provider of services may select any electronic visit verification system that meets the requirements established by the commissioner.

(b) All electronic visit verification systems used by providers to comply with the requirements established by the commissioner must provide data to the commissioner in a format and at a frequency to be established by the commissioner.

(c) Providers must implement the electronic visit verification systems required under this section by a date established by the commissioner to be set after the state-selected electronic visit verification systems for personal care services and home health services are in production. For purposes of this paragraph, "personal care services" and "home health services" have the meanings given in United States Code, title 42, section 1396b(l)(5). Reimbursement rates for providers must not be reduced as a result of federal action to reduce the federal medical assistance percentage under the 21st Century Cures Act, Public Law 114-255.

256B.0943 CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Children's therapeutic services and supports" means the flexible package of mental health services for children who require varying therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness, as defined in section 245.462, subdivision 20, or 245.4871, subdivision 15. The services are time-limited interventions that are delivered using various treatment modalities and combinations of services designed to reach treatment outcomes identified in the individual treatment plan.

(c) "Clinical trainee" means a staff person who is qualified according to section 245I.04, subdivision 6.

(d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

(e) "Culturally competent provider" means a provider who understands and can utilize to a client's benefit the client's culture when providing services to the client. A provider may be culturally competent because the provider is of the same cultural or ethnic group as the client or the provider has developed the knowledge and skills through training and experience to provide services to culturally diverse clients.

(f) "Day treatment program" for children means a site-based structured mental health program consisting of psychotherapy for three or more individuals and individual or group skills training provided by a team, under the treatment supervision of a mental health professional.

(g) "Direct service time" means the time that a mental health professional, clinical trainee, mental health practitioner, or mental health behavioral aide spends face-to-face with a client and the client's family or providing covered services through telehealth as defined under section 256B.0625, subdivision 3b. Direct service time includes time in which the provider obtains a client's history, develops a client's treatment plan, records individual treatment outcomes, or provides service components of children's therapeutic services and supports. Direct service time does not include time doing work before and after providing direct services, including scheduling or maintaining clinical records.

(h) "Direction of mental health behavioral aide" means the activities of a mental health professional, clinical trainee, or mental health practitioner in guiding the mental health behavioral aide in providing services to a client. The direction of a mental health behavioral aide must be based on the client's individual treatment plan and meet the requirements in subdivision 6, paragraph (b), clause (7).

(i) "Individual treatment plan" means the plan described in section 245I.10, subdivisions 7 and 8.

(j) "Mental health behavioral aide services" means medically necessary one-on-one activities performed by a mental health behavioral aide qualified according to section 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously trained by a mental health professional, clinical trainee, or mental health practitioner and as described in the child's individual treatment plan and individual behavior plan. Activities involve working directly with the child or child's family as provided in subdivision 9, paragraph (b), clause (4).

(k) "Mental health certified family peer specialist" means a staff person who is qualified according to section 245I.04, subdivision 12.

(l) "Mental health practitioner" means a staff person who is qualified according to section 245I.04, subdivision 4.

(m) "Mental health professional" means a staff person who is qualified according to section 245I.04, subdivision 2.

(n) "Mental health service plan development" includes:

(1) development and revision of a child's individual treatment plan; and

(2) administering and reporting standardized outcome measurements approved by the commissioner, as periodically needed to evaluate the effectiveness of treatment.

(o) "Mental illness" has the meaning given in section 245.462, subdivision 20, paragraph (a), for persons at least 18 years of age but under 21 years of age, and has the meaning given in section 245.4871, subdivision 15, for children under 18 years of age.

(p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision 11.

(q) "Rehabilitative services" or "psychiatric rehabilitation services" means interventions to: (1) restore a child or adolescent to an age-appropriate developmental trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric rehabilitation services for children combine coordinated psychotherapy to address internal psychological, emotional, and intellectual processing deficits, and skills training to restore personal and social functioning. Psychiatric rehabilitation services establish a progressive series of goals with each achievement building upon a prior achievement.

(r) "Skills training" means individual, family, or group training, delivered by or under the supervision of a mental health professional, designed to facilitate the acquisition of psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child to self-monitor, compensate for, cope with, counteract, or replace skills deficits or maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

(s) "Standard diagnostic assessment" means the assessment described in section 245I.10, subdivision 6.

(t) "Treatment supervision" means the supervision described in section 245I.06.

Subd. 4. **Provider entity certification.** (a) The commissioner shall establish an initial provider entity application and certification process and recertification process to determine whether a provider entity has an administrative and clinical infrastructure that meets the requirements in subdivisions 5 and 6. A provider entity must be certified for the three core rehabilitation services of psychotherapy, skills training, and crisis planning. The commissioner shall recertify a provider entity every three years using the individual provider's certification anniversary or the calendar year end, whichever is later. The commissioner may approve a recertification extension, in the interest of sustaining services, when a certain date for recertification is identified. The commissioner shall establish a process for decertification of a provider entity and shall require corrective action, medical assistance repayment, or decertification of a provider entity that no longer meets the requirements in this section or that fails to meet the clinical quality standards or administrative standards provided by the commissioner in the application and certification process.

(b) The commissioner must provide the following to providers for the certification, recertification, and decertification processes:

(1) a structured listing of required provider certification criteria;

(2) a formal written letter with a determination of certification, recertification, or decertification, signed by the commissioner or the appropriate division director; and

(3) a formal written communication outlining the process for necessary corrective action and follow-up by the commissioner, if applicable.

(c) For purposes of this section, a provider entity must meet the standards in this section and chapter 245I, as required under section 245I.011, subdivision 5, and be:

(1) an Indian health services facility or a facility owned and operated by a tribe or tribal organization operating as a 638 facility under Public Law 93-638 certified by the state;

(2) a county-operated entity certified by the state; or

(3) a noncounty entity certified by the state.

Subd. 5. **Provider entity administrative infrastructure requirements.** (a) An eligible provider entity shall demonstrate the availability, by means of employment or contract, of at least one backup mental health professional in the event of the primary mental health professional's absence.

(b) In addition to the policies and procedures required under section 245I.03, the policies and procedures must include:

(1) fiscal procedures, including internal fiscal control practices and a process for collecting revenue that is compliant with federal and state laws; and

(2) a client-specific treatment outcomes measurement system, including baseline measures, to measure a client's progress toward achieving mental health rehabilitation goals.

(c) A provider entity that uses a restrictive procedure with a client must meet the requirements of section 245.8261.

Subd. 5a. **Background studies.** The requirements for background studies under section 245I.011, subdivision 5, paragraph (b), may be met by a children's therapeutic services and supports services agency through the commissioner's NETStudy system as provided under sections 245C.03, subdivision 7, and 245C.10, subdivision 8.

Subd. 6. **Provider entity clinical infrastructure requirements.** (a) To be an eligible provider entity under this section, a provider entity must have a clinical infrastructure that utilizes diagnostic assessment, individual treatment plans, service delivery, and individual treatment plan review that are culturally competent, child-centered, and family-driven to achieve maximum benefit for the client. The provider entity must review, and update as necessary, the clinical policies and procedures every three years, must distribute the policies and procedures to staff initially and upon each subsequent update, and must train staff accordingly.

(b) The clinical infrastructure written policies and procedures must include policies and procedures for meeting the requirements in this subdivision:

(1) providing or obtaining a client's standard diagnostic assessment, including a standard diagnostic assessment. When required components of the standard diagnostic assessment are not provided in an outside or independent assessment or cannot be attained immediately, the provider entity must determine the missing information within 30 days and amend the child's standard diagnostic assessment or incorporate the information into the child's individual treatment plan;

(2) developing an individual treatment plan;

(3) providing treatment supervision plans for staff according to section 245I.06. Treatment supervision does not include the authority to make or terminate court-ordered placements of the child. A treatment supervisor must be available for urgent consultation as required by the individual client's needs or the situation;

(4) requiring a mental health professional to determine the level of supervision for a behavioral health aide and to document and sign the supervision determination in the behavioral health aide's supervision plan;

(5) ensuring the immediate accessibility of a mental health professional, clinical trainee, or mental health practitioner to the behavioral aide during service delivery;

(6) providing service delivery that implements the individual treatment plan and meets the requirements under subdivision 9; and

(7) individual treatment plan review. The review must determine the extent to which the services have met each of the goals and objectives in the treatment plan. The review must assess the client's progress and ensure that services and treatment goals continue to be necessary and appropriate to the client and the client's family or foster family.

Subd. 7. **Qualifications of individual and team providers.** (a) An individual or team provider working within the scope of the provider's practice or qualifications may provide service components of children's therapeutic services and supports that are identified as medically necessary in a client's individual treatment plan.

(b) An individual provider must be qualified as a:

(1) mental health professional;

(2) clinical trainee;

(3) mental health practitioner;

(4) mental health certified family peer specialist; or

(5) mental health behavioral aide.

(c) A day treatment team must include one mental health professional or clinical trainee.

Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified provider entity must ensure that:

(1) the provider's caseload size should reasonably enable the provider to play an active role in service planning, monitoring, and delivering services to meet the client's and client's family's needs, as specified in each client's individual treatment plan;

(2) site-based programs, including day treatment programs, provide staffing and facilities to ensure the client's health, safety, and protection of rights, and that the programs are able to implement each client's individual treatment plan; and

(3) a day treatment program is provided to a group of clients by a team under the treatment supervision of a mental health professional. The day treatment program must be provided in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community mental health center under section 245.62; or (iii) an entity that is certified under subdivision 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize the client's mental health status while developing and improving the client's independent living and socialization skills. The goal of the day treatment program must be to reduce or relieve the effects of mental illness and provide training to enable the client to live in the community. The remainder of the structured treatment program may include patient and/or family or group psychotherapy, and individual or group skills training, if included in the client's individual treatment plan. Day treatment programs are not part of inpatient or residential treatment services. When a day treatment group that meets the minimum group size requirement temporarily falls below the minimum group size because of a member's temporary absence, medical assistance covers a group session conducted for the group members in attendance. A day treatment program may provide fewer than the minimally required hours for a particular child during a billing period in which the child is transitioning into, or out of, the program.

(b) To be eligible for medical assistance payment, a provider entity must deliver the service components of children's therapeutic services and supports in compliance with the following requirements:

(1) psychotherapy to address the child's underlying mental health disorder must be documented as part of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive it or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record;

(2) individual, family, or group skills training is subject to the following requirements:

(i) a mental health professional, clinical trainee, or mental health practitioner shall provide skills training;

(ii) skills training delivered to a child or the child's family must be targeted to the specific deficits or maladaptations of the child's mental health disorder and must be prescribed in the child's individual treatment plan;

(iii) group skills training may be provided to multiple recipients who, because of the nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from interaction in a group setting, which must be staffed as follows:

(A) one mental health professional, clinical trainee, or mental health practitioner must work with a group of three to eight clients; or

(B) any combination of two mental health professionals, clinical trainees, or mental health practitioners must work with a group of nine to 12 clients;

(iv) a mental health professional, clinical trainee, or mental health practitioner must have taught the psychosocial skill before a mental health behavioral aide may practice that skill with the client; and

(v) for group skills training, when a skills group that meets the minimum group size requirement temporarily falls below the minimum group size because of a group member's temporary absence, the provider may conduct the session for the group members in attendance;

(3) crisis planning to a child and family must include development of a written plan that anticipates the particular factors specific to the child that may precipitate a psychiatric crisis for the child in the near future. The written plan must document actions that the family should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for direct intervention and support services to the child and the child's family. Crisis planning must include preparing resources designed to address abrupt or substantial changes in the functioning of the child or the child's family when sudden change in behavior or a loss of usual coping mechanisms is observed, or the child begins to present a danger to self or others;

(4) mental health behavioral aide services must be medically necessary treatment services, identified in the child's individual treatment plan.

To be eligible for medical assistance payment, mental health behavioral aide services must be delivered to a child who has been diagnosed with a mental illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must document the delivery of services in written progress notes. Progress notes must reflect implementation of the treatment strategies, as performed by the mental health behavioral aide and the child's responses to the treatment strategies; and

(5) mental health service plan development must be performed in consultation with the child's family and, when appropriate, with other key participants in the child's life by the child's treating mental health professional or clinical trainee or by a mental health practitioner and approved by the treating mental health professional. Treatment plan drafting consists of development, review, and revision by face-to-face or electronic communication. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Medical assistance covers service plan development before completion of the child's individual treatment plan. Service plan development is covered only if a treatment plan is completed for the child. If upon review it is determined that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

Subd. 11. **Documentation and billing.** (a) A provider entity must document the services it provides under this section. The provider entity must ensure that documentation complies with Minnesota Rules, parts 9505.2175 and 9505.2197. Services billed under this section that are not documented according to this subdivision shall be subject to monetary recovery by the commissioner. Billing for covered service components under subdivision 2, paragraph (b), must not include anything other than direct service time.

(b) Required documentation must be completed for each individual provider and service modality for each day a child receives a service under subdivision 2, paragraph (b).

609.466 MEDICAL ASSISTANCE FRAUD.

Any person who, with the intent to defraud, presents a claim for reimbursement, a cost report or a rate application, relating to the payment of medical assistance funds pursuant to chapter 256B, to the state agency, which is false in whole or in part, is guilty of an attempt to commit theft of public funds and may be sentenced accordingly.

9505.2165 DEFINITIONS.

Subp. 4. **Fraud.** "Fraud" means:

A. acts which constitute a crime against any program, or attempts or conspiracies to commit those crimes, including the following:

(1) theft in violation of Minnesota Statutes, section 609.52;

(2) perjury in violation of Minnesota Statutes, section 609.48;

(3) aggravated forgery and forgery in violation of Minnesota Statutes, sections 609.625 and 609.63;

(4) medical assistance fraud in violation of Minnesota Statutes, section 609.466; and

(5) financial transaction card fraud in violation of Minnesota Statutes, section 609.821;

B. making a false statement, false claim, or false representation to a program where the person knows or should reasonably know the statement, claim, or representation is false, including knowingly and willfully submitting a false or fraudulent application for provider status; and

C. a felony listed in United States Code, title 42, section 1320a-7b(b)(3)(D), subject to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section 952.