Senator ..... moves to amend S.F. No. 4612 as follows:

Delete everything after the enacting clause and insert:

"ARTICLE 1

DEPARTMENT OF HEALTH

Section 1. Minnesota Statutes 2024, section 62U.04, subdivision 13, is amended to read:

Subd. 13. **Expanded access to and use of the all-payer claims data.** (a) The commissioner or the commissioner's designee shall make the data submitted under subdivisions 4, 5, 5a, and 5b, including data classified as private or nonpublic, available to individuals and organizations engaged in research on, or efforts to effect transformation in, health care outcomes, access, quality, disparities, or spending, provided the use of the data serves a public benefit. Data made available under this subdivision may not be used to:

(1) create an unfair market advantage for any participant in the health care market in Minnesota, including health plan companies, payers, and providers;

(2) reidentify or attempt to reidentify an individual in the data; or

(3) publicly report contract details between a health plan company and provider and derived from the data.

(b) To implement paragraph (a), the commissioner shall:

(1) establish detailed requirements for data access; a process for data users to apply to access and use the data; legally enforceable data use agreements to which data users must consent; a clear and robust oversight process for data access and use, including a data management plan, that ensures compliance with state and federal data privacy laws; agreements for state agencies and the University of Minnesota to ensure proper and efficient use and security of data; and technical assistance for users of the data and for stakeholders;

(2) ~~develop a~~ assess fees according to the fee schedule in subdivision 14 to support the cost of expanded access to and use of the data, provided the fees charged under the schedule do not create a barrier to access or use for those most affected by disparities; ~~and~~

(3) create a research advisory group to advise the commissioner on applications for data use under this subdivision, including an examination of the rigor of the research approach, the technical capabilities of the proposed user, and the ability of the proposed user to successfully safeguard the data~~.~~; and

(4) annually publish on the Department of Health website a list of projects authorized under this subdivision.

Sec. 2. Minnesota Statutes 2024, section 62U.04, is amended by adding a subdivision to read:

Subd. 14. **Fees for expanded access to and use of the all-payer claims database.** (a) For purposes of this section:

(1) "custom data set or analysis" means a de-identified data set or report for which a standard data set or limited use data sets are not appropriate, that only provides the minimum necessary data, and that is de-identified using the expert determination method as defined in Code of Federal Regulations, title 45, section 164.514(b)(1);

(2) "data file" means a data file derived from medical claims, pharmacy claims, dental claims, eligibility information, membership information, or provider information for a single year;

(3) "limited use data set" means a data set that meets the requirements in Code of Federal Regulations, title 45, section 164.514(e)(2), and may include protected health information from which certain direct identifiers of individuals have been removed under the principle of minimum information necessary; and

(4) "standard data set" means a static data release designed by the commissioner to serve a wide range of projects in which nearly all de-identified data elements are disclosed in one release after applying the safe harbor de-identification method defined in Code of Federal Regulations, title 45, section 164.514(b)(2), and from which protected health information and any combination of data elements that directly identify any person are excluded.

(b) The commissioner must assess fees on an individual or organization that receives data under subdivision 13 for the cost of accessing or receiving the data. Costs under this paragraph may include but are not limited to the cost of producing and releasing data to the individual or organization under subdivision 13 and managing infrastructure and operations. The commissioner must assess fees according to the following schedule based on the type of data requested and number of years for which access is requested:

(1) the fee for a standard data set is $3,500 per data file per year;

(2) the fee for a limited use data set is $7,000 per data file per year; and

(3) the fee for a custom data set or analysis is $89 per hour of staff time expended, but the fee must not exceed $5,785.

(c) An individual or organization that receives approval to access or receive data under subdivision 13 must pay all the required fees in full before accessing or receiving the requested data.

(d) The commissioner may grant a partial or full waiver of the fees in paragraph (b) if the individual or organization requesting the data meets at least one of the following criteria:

(1) the fees represent a financial hardship to the individual or organization;

(2) the organization is a self-insured data submitter under this section;

(3) the individual or organization is affiliated with an academic institution;

(4) the individual or organization requests a high volume of data files; or

(5) the request is from a Tribal health director for, or the governing body of, one of the 11 federally recognized Tribes in Minnesota.

In determining whether to grant a waiver under this paragraph, the commissioner may consult the research advisory group established under subdivision 13.

(e) Fees paid by an individual or organization approved to access or receive data under subdivision 13 are nonrefundable. Fees collected under this subdivision must be deposited into an account in the special revenue fund. Money in that account does not cancel and is appropriated to the commissioner to offset the cost of providing access to data under subdivision 13 and maintaining data submitted under subdivisions 4 to 5b.

(f) The commissioner must publish the fee schedule in paragraph (b) on the Department of Health website.

Sec. 3. Minnesota Statutes 2025 Supplement, section 144.125, subdivision 1, is amended to read:

Subdivision 1. **Duty to perform testing.** (a) It is the duty of (1) the administrative officer or other person in charge of each institution caring for infants 28 days or less of age, (2) the person required in pursuance of the provisions of section 144.215, to register the birth of a child, or (3) the nurse midwife or midwife in attendance at the birth, to arrange to have administered to every infant or child in its care tests for heritable and congenital disorders according to subdivision 2 and rules prescribed by the state commissioner of health.

(b) Testing, recording of test results, reporting of test results, and follow-up of infants with heritable congenital disorders, including hearing loss detected through the early hearing detection and intervention program in section 144.966, shall be performed at the times and in the manner prescribed by the commissioner of health.

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be $184.35 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund. If the individual described in paragraph (a) submits a claim for reimbursement to an insurer but does not receive reimbursement, the individual may request a special fee exemption form from the newborn screening program. To qualify for the exemption, the individual must provide documentation to the newborn screening program that the insurer did not reimburse them.

(d) The fee to offset the cost of the support services provided under section 144.966, subdivision 3a, shall be $15 per specimen. This fee shall be deposited in the state treasury and credited to the general fund.

Sec. 4. Minnesota Statutes 2024, section 144.1501, subdivision 2, is amended to read:

Subd. 2. **Availability.** (a) The commissioner of health shall use money appropriated for health professional education loan forgiveness in this section:

(1) for medical residents, physicians, mental health professionals, and alcohol and drug counselors agreeing to practice in designated rural areas or underserved urban communities or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas or to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(3) for nurses who agree to practice in a Minnesota nursing home; in an intermediate care facility for persons with developmental disability; in a hospital if the hospital owns and operates a Minnesota nursing home and a minimum of 50 percent of the hours worked by the nurse is in the nursing home; in an assisted living facility as defined in section 144G.08, subdivision 7; or for a home care provider as defined in section 144A.43, subdivision 4; or agree to teach at least 12 credit hours, or 720 hours per year in the nursing field in a postsecondary program at the undergraduate level or the equivalent at the graduate level;

(4) for other health care technicians agreeing to teach at least 12 credit hours, or 720 hours per year in their designated field in a postsecondary program at the undergraduate level or the equivalent at the graduate level. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the

need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology;

(5) for pharmacists, advanced dental therapists, dental therapists, and public health nurses who agree to practice in designated rural areas;

(6) for dentists agreeing to deliver at least 25 percent of the dentist's yearly patient encounters to state public program enrollees or patients receiving sliding fee schedule discounts through a formal sliding fee schedule meeting the standards established by the United States Department of Health and Human Services under Code of Federal Regulations, title 42, section 51c.303; and

(7) for nurses employed as a hospital nurse by a nonprofit hospital and providing direct care to patients at the nonprofit hospital.

(b) Appropriations made for health professional education loan forgiveness in this section do not cancel and are available until expended~~, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund~~.

Sec. 5. Minnesota Statutes 2024, section 144.1503, subdivision 7, is amended to read:

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

Sec. 6. Minnesota Statutes 2024, section 144.1505, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(1) "eligible advanced practice registered nurse program" means a program that is located in Minnesota and is currently accredited as a master's, doctoral, or postgraduate level advanced practice registered nurse program by the Commission on Collegiate Nursing Education or by the Accreditation Commission for Education in Nursing, or ~~is~~ presents a credible plan as a candidate for accreditation;

(2) "eligible dental therapy program" means a dental therapy education program or advanced dental therapy education program that is located in Minnesota and is either:

(i) is approved by the Board of Dentistry; ~~or~~

(ii) is currently accredited by the Commission on Dental Accreditation; or

(iii) presents a credible plan as a candidate for accreditation;

(3) "eligible mental health professional program" means a program that is located in Minnesota and is ~~listed~~ currently accredited as a mental health professional program by the appropriate accrediting body for clinical social work, psychology, marriage and family therapy, or licensed professional clinical counseling, or ~~is~~ presents a credible plan as a candidate for accreditation;

(4) "eligible pharmacy program" means a program that is located in Minnesota and is currently accredited as a doctor of pharmacy program by the Accreditation Council on Pharmacy Education or presents a credible plan as a candidate for accreditation;

(5) "eligible physician assistant program" means a program that is located in Minnesota and is currently accredited as a physician assistant program by the Accreditation Review Commission on Education for the Physician Assistant, or ~~is~~ presents a credible plan as a candidate for accreditation;

(6) "mental health professional" means an individual providing clinical services in the treatment of mental illness who meets one of the qualifications under section 245.462, subdivision 18;

(7) "eligible physician training program" means a medical school training program or a physician residency training program located in Minnesota and that is currently accredited by the accrediting body or has presented a credible plan as a candidate for accreditation;

(8) "eligible dental program" means a dental education program or a dental residency training program located in Minnesota and that is currently accredited by the accrediting body or has presented a credible plan as a candidate for accreditation; ~~and~~

(9) "rural community" means a Tribal Nation, statutory city, home rule charter city, or township in Minnesota that is outside the seven-county metropolitan area as defined in section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud;

(10) "underserved community" means a Minnesota area or population included in the list of designated primary medical care health professional shortage areas, medically

underserved areas, or medically underserved populations maintained and updated by the United States Department of Health and Human Services; and

(11) "project" means a project to ~~establish or expand~~ (i) plan or implement a new eligible clinical training ~~for physician assistants, advanced practice registered nurses, pharmacists, dental therapists, advanced dental therapists, or mental health professionals in Minnesota~~ program or increase the base number of trainees in an existing eligible clinical training program, or (ii) add or expand rural rotations or clinical training experiences in an existing eligible clinical training program.

Sec. 7. Minnesota Statutes 2024, section 144.1505, subdivision 2, is amended to read:

Subd. 2. **Programs.** (a) For advanced practice provider clinical training expansion grants, the commissioner of health shall award ~~health professional training site~~ grants to eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, and mental health professional programs to plan and implement ~~expanded~~ a new eligible clinical training program or increase the base number of trainees in an existing eligible clinical training program. Clinical training must take place in a rural community or an underserved community. A planning grant shall not exceed $75,000, and a three-year training grant shall not exceed $300,000 per project. The commissioner may provide a ~~one-year,~~ no-cost extension for grants.

(b) For health professional rural ~~and underserved~~ clinical rotations grants, the commissioner of health shall award ~~health professional training site~~ grants to existing eligible physician, physician assistant, advanced practice registered nurse, pharmacy, dentistry, dental therapy, and mental health professional training programs to ~~augment existing clinical training programs to~~ add, expand, or enhance rural ~~and underserved~~ rotations or clinical training experiences, such as credential or certificate rural tracks or other specialized training. Rotations and clinical training experiences must take place in rural communities. For physician and dentist training, the expanded training must include rotations in primary care settings such as community clinics, hospitals, health maintenance organizations, or practices in rural communities.

(c) Advanced practice provider clinical training expansion grant funds may be used for:

(1) ~~establishing or expanding rotations~~ planning and implementing a new clinical training program or increasing the base number of trainees in an existing clinical training program as described in paragraph (a);

(2) recruitment, training, and retention of students ~~and~~, faculty, and preceptors;

(3) connecting students with appropriate clinical training sites, internships, practicums, or externship ~~activities~~ opportunities;

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, incentives, or other financial support;

(6) development and implementation of health equity and cultural ~~competency~~ responsiveness training;

(7) evaluations of the clinical training program to inform program improvements;

(8) training site improvements, fees, equipment, and supplies required to establish, maintain, or expand a training program; ~~and~~

(9) supporting clinical education in which trainees are part of a primary care team model~~.~~;; and

(10) onboarding expenses for trainees to meet clinical training site requirements.

(d) Health professional rural clinical rotation grant funds may be used for:

(1) adding, expanding, or enhancing rural rotations and clinical training experiences in an existing clinical training program as described in paragraph (b);

(2) recruitment, training, and retention of students, faculty, and preceptors;

(3) connecting students with appropriate clinical training sites, internships, practicums, or externship opportunities;

(4) travel and lodging for students;

(5) faculty, student, and preceptor salaries, stipends, or other financial support;

(6) development and implementation of health equity and cultural responsiveness training;

(7) evaluations of the rural rotation or clinical training experience to inform program improvements;

(8) training site improvements, fees, equipment, and supplies required to establish or expand rural rotations or clinical training experiences;

(9) supporting clinical education in which trainees are part of a primary care team model; and

(10) onboarding expenses for trainees to meet clinical training site requirements.

Sec. 8. Minnesota Statutes 2024, section 144.1505, subdivision 3, is amended to read:

Subd. 3. **Applications.** Eligible physician assistant, advanced practice registered nurse, pharmacy, dental therapy, dental, physician, and mental health professional programs seeking a grant shall apply to the commissioner. Applications for advanced practice provider clinical training expansion grants must include a description of the number of additional students who will be trained using grant funds~~;~~ and attestation that funding will be used to support an increase in the number of clinical training slots~~;~~.

All applications must include a description of the problem that the proposed project will address; a description of the project, including all costs associated with the project, sources of funds for the project, detailed uses of all funds for the project, and the results expected~~;~~, and a plan to maintain or operate ~~any component included in~~ the project after the grant period, including a description of potential barriers to sustainability.

~~The applicant~~ Applicants must describe achievable objectives, a timetable, and roles and capabilities of responsible individuals in the organization.

~~Applicants applying under subdivision 2, paragraph (b),~~ Applications for rural clinical rotation grants must include a description of the new, expanded, or enhanced rural rotations or clinical training experiences; attestation that funding will be used to support improved rural clinical training experiences; and information about length of training and training site settings, geographic location of rural sites, and rural populations expected to be served.

Sec. 9. Minnesota Statutes 2024, section 144.1507, subdivision 1, is amended to read:

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

(b) "Eligible program" means a program that meets the following criteria:

(1) is located in Minnesota;

(2) trains medical residents in the specialties of family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, or general surgery in rural residency training programs or in community-based ambulatory care centers that primarily serve the underserved, or trains postdoctoral psychology residents; and

(3) is accredited by the Accreditation Council for Graduate Medical Education or the American Psychological Association or presents a credible plan to obtain accreditation.

(c) "Rural community" means a Tribal Nation, statutory city, home rule charter city, or township in Minnesota that is outside the seven-county metropolitan area as defined in

section 473.121, subdivision 2, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

~~(c)~~ (d) "Rural residency training program" means a rural medical residency program or a rural psychology residency program that provides ~~an initial year of~~ training in an accredited residency program in Minnesota. ~~The subsequent years of the residency program are~~ At least two-thirds of the residency training must be based in rural communities, utilizing local clinics and community hospitals, with specialty rotations in nearby regional medical centers. When specialty rotations cannot take place within rural communities, training may occur in nonrural sites provided that at least one-half of all training occurs in rural communities. For residency training programs in general surgery, pediatrics, and psychiatry, at least one-half of the residency training must be based in communities outside the seven-county metropolitan area, with rotations in rural communities.

~~(d)~~ (e) "Community-based ambulatory care centers" means federally qualified health centers, community mental health centers, rural health clinics, health centers operated by the Indian Health Service, an Indian Tribe or Tribal organization, or an urban American Indian organization or an entity receiving funds under Title X of the Public Health Service Act.

~~(e)~~ (f) "Eligible project" means a project to establish and maintain a rural residency training program.

Sec. 10. Minnesota Statutes 2024, section 144.1507, subdivision 2, is amended to read:

Subd. 2. **Rural residency training program.** (a) The commissioner of health shall award rural residency training program grants to eligible programs to plan, implement, and sustain rural residency training programs. A rural medical residency training program grant shall not exceed $250,000 per year for up to three years for planning and development, and $225,000 per resident per year for each year thereafter to sustain the program. A rural psychology residency training program grant shall not exceed $150,000 per year for up to three years for planning and development, and $150,000 per resident per year for each year thereafter to sustain the program. Medical and psychology residency programs that meet eligibility guidelines and continue to demonstrate financial need will be granted sustaining funds, renewable every five years.

(b) Funds may be spent to cover the costs of:

(1) planning related to establishing accredited rural residency training programs;

(2) obtaining accreditation by the Accreditation Council for Graduate Medical Education, the American Psychological Association, or another national body that accredits rural residency training programs;

(3) establishing new rural residency training programs;

(4) recruitment, training, and retention of new residents and faculty related to the new rural residency training program;

(5) travel and lodging for new residents;

(6) faculty, new resident, and preceptor salaries related to new rural residency training programs;

(7) training site improvements, fees, equipment, and supplies required for new rural residency training programs; and

(8) supporting clinical education in which trainees are part of a primary care team model.

Sec. 11. Minnesota Statutes 2024, section 144.1507, subdivision 4, is amended to read:

Subd. 4. **Consideration of grant applications.** The commissioner shall review each application to determine if the residency program application is complete, if the proposed rural residency program and residency slots are eligible for a grant, and if the program is eligible for federal graduate medical education funding, and when the funding is available. If eligible programs are not eligible for federal graduate medical education funding, the commissioner may award continuation funding to the eligible program beyond the initial grant period without requiring a competitive application. The commissioner shall award grants to support training programs in family medicine, general internal medicine, general pediatrics, psychiatry, geriatrics, general surgery, psychology, and other primary care focus areas.

Sec. 12. Minnesota Statutes 2024, section 144.1507, is amended by adding a subdivision to read:

Subd. 6. **Clinical training program coordination.** The commissioner may award grants to the University of Minnesota to provide technical assistance to residency training programs for coordinated development of rural clinical training programs statewide.

Sec. 13. Minnesota Statutes 2024, section 144.1911, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The international medical graduates assistance program is established to address barriers to practice and facilitate pathways to assist immigrant

international medical graduates to integrate into the Minnesota health care delivery system, with the goal of increasing access to primary care in rural and underserved areas of the state. Notwithstanding any law to the contrary, appropriations made to the program do not cancel and are available until expended.

Sec. 14. Minnesota Statutes 2024, section 144.1911, subdivision 5, is amended to read:

Subd. 5. **Clinical preparation.** (a) The commissioner shall award grants to support clinical preparation for Minnesota international medical graduates needing additional clinical preparation or experience to qualify for residency. The grant program shall include:

(1) proposed training curricula;

(2) associated policies and procedures for clinical training sites, which must be part of existing clinical medical education programs in Minnesota; and

(3) monthly stipends for international medical graduate participants. Priority shall be given to primary care sites in rural or underserved areas of the state~~, and~~. International medical graduate participants who receive funding through the international medical graduate primary care residency grant program must commit to serving at least five years in a rural or underserved community of the state.

(b) The policies and procedures for the clinical preparation grants must be developed by December 31, 2015, including an implementation schedule that begins awarding grants to clinical preparation programs beginning in June of 2016.

Sec. 15. Minnesota Statutes 2024, section 144.1911, subdivision 6, is amended to read:

Subd. 6. **International medical graduate primary care residency grant program and revolving account.** (a) The commissioner shall award grants to support primary care residency positions designated for Minnesota immigrant physicians who are willing to serve in rural or underserved areas of the state. No grant shall exceed $150,000 per residency position per year. Eligible primary care residency grant recipients include accredited family medicine, general surgery, internal medicine, obstetrics and gynecology, psychiatry, and pediatric residency programs. Eligible primary care residency programs shall apply to the commissioner. Applications must include the number of anticipated residents to be funded using grant funds and a budget. ~~Notwithstanding any law to the contrary, funds awarded to grantees in a grant agreement do not lapse until the grant agreement expires.~~ Before any funds are distributed, a grant recipient shall provide the commissioner with the following:

(1) a copy of the signed contract between the primary care residency program and the participating international medical graduate;

(2) certification that the participating international medical graduate has lived in Minnesota for at least two years and is certified by the Educational Commission on Foreign Medical Graduates. Residency programs may also require that participating international medical graduates hold a Minnesota certificate of clinical readiness for residency, once the certificates become available; and

(3) verification that the participating international medical graduate has executed a participant agreement pursuant to paragraph (b).

(b) Upon acceptance by a participating residency program, international medical graduates shall enter into an agreement with the commissioner to provide primary care for at least five years in a rural or underserved area of Minnesota after graduating from the residency program and make payments to the revolving international medical graduate residency account for five years beginning in their second year of postresidency employment. Participants shall pay $15,000 or ten percent of their annual compensation each year, whichever is less.

(c) A revolving international medical graduate residency account is established as an account in the special revenue fund in the state treasury. The commissioner of management and budget shall credit to the account appropriations, payments, and transfers to the account. Earnings, such as interest, dividends, and any other earnings arising from fund assets, must be credited to the account. Funds in the account are appropriated annually to the commissioner to award grants and administer the grant program established in paragraph (a). Notwithstanding any law to the contrary, any funds deposited in the account do not expire. The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any grant issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the account, as well as the amount of the contribution provided; and

(3) a contributing entity may not specify that the recipient or recipients of any funds use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

Sec. 16. Minnesota Statutes 2024, section 145A.14, subdivision 2a, is amended to read:

Subd. 2a. **Tribal governments.** (a) Of the funding available for local public health grants, $1,500,000 per year is available to Tribal governments for:

(1) maternal and child health activities ~~under section 145.882, subdivision 7~~;

(2) activities to reduce health ~~disparities under section 145.928, subdivision 10~~; ~~and~~

(3) emergency preparedness; and

(4) additional public health activities identified by each Tribal government.

(b) The commissioner, in consultation with Tribal governments, shall establish a formula for distributing the funds and developing the outcomes to be measured.

Sec. 17. **[1031.2091] SUBMERGED CLOSED LOOP HEAT EXCHANGER SYSTEM; VARIANCES.**

(a) The commissioner must consider a variance for an undue burden under Minnesota Rules, part 4717.7010, to isolation distance requirements for a water supply well used in a submerged closed loop heat exchanger system if:

(1) the water supply well will be used for the sole purpose of heating and cooling;

(2) the water supply well will be constructed with additional protective casing and grout to prevent potential contamination of the well and groundwater and will exceed the well construction standards in Minnesota Rules, parts 4725.3050, subpart 3, and 4725.4825, sufficient to protect against potential contamination sources associated with the isolation distance requirements; and

(3) strict compliance with the isolation distance requirements would prevent the property owner from installing an effectively designed submerged closed loop heat exchanger system.

(b) The variance application must include an evaluation by a third-party licensed professional engineer that quantifies a loss of system efficiency or describes a loss of construction feasibility for the submerged closed loop heat exchanger system that results from complying with isolation distance requirements. Any licensed professional engineer that is not employed by the variance applicant or the firm designing the submerged closed loop heat exchanger system is considered a third party under this statute.

ARTICLE 2
DEPARTMENT OF HUMAN SERVICES

Section 1. **[245A.034] LICENSEE CONDUCT TOWARD PUBLIC OFFICIALS.**

(a) Applicants, license holders, certification holders, and controlling individuals must not engage in conduct that threatens the safety or well-being of Department of Human Services staff, county employees, or other individuals acting under the authority of the commissioner for duties authorized under this chapter, chapter 260E, or section 626.557. The conduct described under this paragraph includes but is not limited to:

(1) assault, including attempts, under sections 609.221, 609.222, 609.223, 609.2231, and 609.224, regardless of whether there is a criminal proceeding or conviction;

(2) threats of violence under section 609.713, regardless of whether there is a criminal proceeding or conviction;

(3) harassment or stalking under section 609.749, regardless of whether there is a criminal proceeding or conviction;

(4) damage to property under section 609.595, regardless of whether there is a criminal proceeding or conviction; or

(5) any other act with the intent to cause harm to personal safety.

(b) If the commissioner determines that an applicant, license holder, certification holder, or controlling individual engaged in conduct described under paragraph (a) against an individual performing licensing, certification, investigation, or compliance activities, the commissioner may take action under section 245A.05, 245A.06, or 245A.07 against the applicant, license holder, certification holder, or controlling individual.

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

Sec. 2. Minnesota Statutes 2025 Supplement, section 245A.07, subdivision 3, is amended to read:

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

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

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

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

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

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

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

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

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. If the order is issued through the provider hub, the appeal must be received by the commissioner within ten calendar days from the date the commissioner issued the order through the hub. Except as provided in subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided in section 245A.04, subdivision 7, paragraphs (i) and (j), until the commissioner issues a final order on the suspension or revocation.

(c)(1) If the license holder was ordered to pay a fine, the notice must inform the license holder of the responsibility for payment of fines and the right to a contested case hearing

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

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

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

(4) Fines shall be assessed as follows:

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

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

(iii) the license holder shall forfeit ~~$200~~ $500 for each occurrence of a violation of law or rule governing matters of health, safety, or supervision, including but not limited to the

provision of adequate staff-to-child or adult ratios, and failure to comply with background study requirements under chapter 245C; and

(iv) the license holder shall forfeit ~~$100~~ $300 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, or $200 fine in items (i) to (iii).

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

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

(d) Except for background study violations involving the failure to comply with an order to immediately remove an individual or an order to provide continuous, direct supervision, the commissioner shall not issue a fine under paragraph (c) relating to a background study violation to a license holder who self-corrects a background study violation before the commissioner discovers the violation. A license holder who has previously exercised the provisions of this paragraph to avoid a fine for a background study violation may not avoid a fine for a subsequent background study violation unless at least 365 days have passed since the license holder self-corrected the earlier background study violation.

Sec. 3. Minnesota Statutes 2025 Supplement, section 256.9657, subdivision 2b, is amended to read:

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

(1) "eligible hospital" means:

(i) PrairieCare psychiatric hospital; or

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

(A) federal Indian Health Service facilities;

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

(C) federal Veterans Administration Medical Centers; and

(D) long-term acute care hospitals;

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

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

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

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

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

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

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

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

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

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

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

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

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

(e) The commissioner may, after consultation with the Minnesota Hospital Association, modify the rates of assessment in paragraph (b) as necessary to comply with federal law,

obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or otherwise maximize under this section federal financial participation for medical assistance. Notwithstanding the foregoing authorization to maximize federal financial participation for medical assistance, the commissioner must reduce the rates of assessment in paragraph (b) as necessary to ensure:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(5) each hospital not included in another discount category, and with greater than $200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service

and managed care, as reported in state fiscal year 2022 medical assistance fee-for-service and managed care claims data, with a discount of ten percent.

(p) The commissioner must not impose any assessment under this subdivision on a hospital that does not receive payments under section 256B.1974.

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

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

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

Sec. 4. Minnesota Statutes 2025 Supplement, section 256.969, subdivision 2f, is amended to read:

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

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

received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received 99 percent of the entire amount calculated under subdivision 9, paragraph (d). Hospitals that do not meet federal requirements for Medicaid disproportionate share hospitals are not eligible for the alternate payment rate.

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

Sec. 5. Minnesota Statutes 2024, section 256B.056, subdivision 1, is amended to read:

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

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

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

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

Sec. 6. Minnesota Statutes 2025 Supplement, section 256B.1973, subdivision 9, is amended to read:

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

hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both.

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

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

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

Sec. 7. Minnesota Statutes 2024, section 256B.75, is amended to read:

256B.75 HOSPITAL OUTPATIENT REIMBURSEMENT.

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

(b) Notwithstanding paragraph (a), payment for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals designated under section 144.1483, clause (9), shall be paid on a cost-based payment system that is based on the cost-finding methods and allowable costs of the Medicare program. Effective for services provided on or after July 1, 2015, rates established for critical access hospitals under this paragraph for the applicable payment year shall be the final payment and shall not be settled to actual costs. Effective for services delivered on or after the first day of the hospital's fiscal year ending in 2017, the rate for outpatient hospital services shall be computed using information from each hospital's Medicare cost report as filed with Medicare for the year that is two years before the year that the rate is being computed. Rates shall be computed using information from Worksheet C series until the department finalizes the medical assistance cost reporting process for critical access hospitals. After the cost reporting process is finalized, rates shall be computed using information from Title XIX Worksheet D series. The outpatient rate shall be equal to ancillary cost plus outpatient cost, excluding costs related to rural health clinics and federally qualified health clinics, divided by ancillary charges plus outpatient charges, excluding charges related to rural health clinics and federally qualified health clinics. Effective for services delivered on or after January 1, 2024, the rates paid to critical access hospitals under this section must be adjusted to include the amount of any distributions under section 62J.692, subdivision 4, paragraph (a), that were not included in the rate adjustment described under section 256.969, subdivision 2b, paragraph (k).

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

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

(e) In addition to the reduction in paragraph (d), the total payment for fee-for-service services provided on or after July 1, 2003, made to hospitals for outpatient hospital facility services before third-party liability and spenddown, is reduced five percent from the current

statutory rates. Facilities defined under section 256.969, subdivision 16, are excluded from this paragraph.

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

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

Sec. 8. **REPEALER.**

Minnesota Statutes 2024, section 256B.198, is repealed.

ARTICLE 3
HUMAN SERVICES FEDERAL COMPLIANCE

Section 1. Minnesota Statutes 2024, section 245.4711, subdivision 5, is amended to read:

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

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

Sec. 2. Minnesota Statutes 2024, section 245.4881, subdivision 5, is amended to read:

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

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

Sec. 3. 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. 4. 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. 5. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision to read:

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

Sec. 6. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to read:

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

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

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

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

Sec. 7. Minnesota Statutes 2024, section 256B.04, subdivision 27, is amended to read:

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

~~information available through managed care and county-based purchasing plans, state health and human services programs, and other sources~~.

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

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

Sec. 8. Minnesota Statutes 2024, section 256B.056, subdivision 2a, is amended to read:

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

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

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

~~(c)~~ (d) A person denied or terminated from medical assistance payment of long-term care services because the person's home equity exceeds the home equity limit may seek a waiver based upon a hardship by filing a written request with the county agency. Hardship is an imminent threat to the person's health and well-being that is demonstrated by documentation of no alternatives for payment of long-term care services. The county agency shall make a decision regarding the written request to waive the home equity limit within

30 days if all necessary information has been provided. The county agency shall send the person and the person's representative a written notice of decision on the request for a demonstrated hardship waiver that also advises the person of appeal rights under the fair hearing process of section 256.045.

Sec. 9. Minnesota Statutes 2024, section 256B.056, subdivision 7, is amended to read:

Subd. 7. **Period of eligibility.** (a) Eligibility is available for the month of application and for three months prior to application if the person was eligible in those prior months. ~~A redetermination of eligibility must occur every 12 months.~~

(b) Notwithstanding any other law to the contrary:

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

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

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

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

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

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

(3) the child dies;

(4) the child attains the maximum age; or

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

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

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

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

Sec. 10. Minnesota Statutes 2024, section 256B.056, subdivision 7a, is amended to read:

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2024, section 256B.0561, subdivision 2, is amended to read:

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

(b) If data matching indicates a recipient may no longer qualify for medical assistance or MinnesotaCare, the commissioner must notify the recipient and allow the recipient no more than 30 days to confirm the information obtained through the periodic data matching

or provide a reasonable explanation for the discrepancy to the state or county agency directly responsible for the recipient's case. If a recipient does not respond within the advance notice period or does not respond with information that demonstrates eligibility or provides a reasonable explanation for the discrepancy within the 30-day time period, the commissioner shall terminate the recipient's eligibility in the manner provided for by the laws and regulations governing the health care program for which the recipient has been identified as being ineligible.

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

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

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

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

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

Sec. 12. **[256B.0562] WORK OR COMMUNITY ENGAGEMENT REQUIREMENTS.**

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

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

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

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

(1) the person works at least 80 hours;

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

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

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

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

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

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

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

(1) is an American Indian or Alaska Native;

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

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

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

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

(ii) has a substance use disorder;

(iii) has a disabling mental disorder;

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

(v) has a serious or complex medical condition;

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

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

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

(8) is incarcerated.

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

(1) described in paragraph (b);

(2) under 21 years of age;

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

(4) enrolled in medical assistance under an eligibility category described in section 1902(a)(10)(A)(i), subclauses (I) to (VII), of the Social Security Act; or

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

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

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

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

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

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

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

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

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

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

(1) a notice of noncompliance; and

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

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

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

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

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

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

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

Sec. 13. Minnesota Statutes 2024, section 256B.06, subdivision 4, is amended to read:

Subd. 4. **Citizenship requirements.** (a) Eligibility for medical assistance is limited to citizens of the United States, qualified noncitizens as defined in this subdivision, and other

persons residing lawfully in the United States. Citizens or nationals of the United States must cooperate in obtaining satisfactory documentary evidence of citizenship or nationality according to the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(iii) services for routine prenatal care;

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

(v) elective surgery;

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

(vii) preventative health care and family planning services;

(viii) rehabilitation services;

(ix) physical, occupational, or speech therapy;

(x) transportation services;

(xi) case management;

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

(xiii) dental services;

(xiv) hospice care;

(xv) audiology services and hearing aids;

(xvi) podiatry services;

(xvii) chiropractic services;

(xviii) immunizations;

(xix) vision services and eyeglasses;

(xx) waiver services;

(xxi) individualized education programs; or

(xxii) substance use disorder treatment.

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

(j) Beginning October 1, 2003, persons who are receiving care and rehabilitation services from a nonprofit center established to serve victims of torture and are otherwise ineligible for medical assistance under this chapter are eligible for medical assistance without federal financial participation. These individuals are eligible only for the period during which they are receiving services from the center. Individuals eligible under this paragraph shall not be required to participate in prepaid medical assistance. The nonprofit center referenced under this paragraph may establish itself as a provider of mental health targeted case management services through a county contract under section 256.0112, subdivision 6. If the nonprofit center is unable to secure a contract with a lead county in its service area, then, notwithstanding the requirements of section 256B.0625, subdivision 20, the commissioner may negotiate a contract with the nonprofit center for provision of mental health targeted case management services. When serving clients who are not the financial responsibility of their contracted lead county, the nonprofit center must gain the concurrence of the county of financial responsibility prior to providing mental health targeted case management services for those clients.

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

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

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

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

(l) Effective July 1, 2013, recipients of emergency medical assistance under this subdivision are eligible for coverage of the elderly waiver services provided under chapter 256S, and coverage of rehabilitative services provided in a nursing facility. The age limit for elderly waiver services does not apply. In order to qualify for coverage, a recipient of

emergency medical assistance is subject to the assessment and reassessment requirements of section 256B.0911. Initial and continued enrollment under this paragraph is subject to the limits of available funding.

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

Sec. 14. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 20, is amended to read:

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

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

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

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

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

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

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

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

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

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

(c) Medical assistance and MinnesotaCare payment for mental health case management ~~shall~~ must be made ~~on a monthly basis~~ in accordance with section 256B.076, subdivisions 1, 2, 5, and 6. ~~In order to receive payment for an eligible child, the provider must document at least a face-to-face contact either in person or by interactive video that meets the requirements of subdivision 20b with the child, the child's parents, or the child's legal representative. To receive payment for an eligible adult, the provider must document:~~

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

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

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

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

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

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

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

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

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

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

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

(2) programming the information systems.

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

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

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

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

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

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

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

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

Sec. 15. Minnesota Statutes 2024, section 256B.076, subdivision 1, is amended to read:

Subdivision 1. **Generally.** (a) It is the policy of this state to ensure that individuals on medical assistance receive cost-effective and coordinated care, including efforts to address the profound effects of housing instability, food insecurity, and other social determinants

of health. Therefore, subject to federal approval, medical assistance covers targeted case management services as described in this section and sections 245.4711, 245.4881, 256B.0625, subdivisions 20 to 20b, 256B.0924, 256B.094, and 256F.10.

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

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

Sec. 16. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision to read:

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

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

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

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

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

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

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

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

Sec. 17. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision to read:

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

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

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

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

Sec. 18. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision to read:

Subd. 7. **Managed care plan units and rates for mental health targeted case management.** The commissioner must ensure that the prepaid health plans providing covered health services for eligible persons pursuant to this chapter and section 256L.03, subdivisions 1a and 1b, reimburse counties at a rate that is at least equal to the fee-for-service rate described in subdivision 5 for targeted case management services provided to Minnesota health care program (MHCP) health plan enrollees covered by medical assistance. If, for any contract year, federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this subdivision. Contracts between managed care plans and county-based purchasing plans and providers to whom this subdivision applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this subdivision. Payment recoveries must not exceed the amount equal to any increase in rates that results from this subdivision. This subdivision expires if federal approval is not received for this subdivision at any time. This subdivision does not obligate MHCP health plans to contract with counties for the provision of targeted case management services.

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

Sec. 19. Minnesota Statutes 2024, section 256B.076, is amended by adding a subdivision to read:

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

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

(c) The base calendar years are the three calendar years immediately before the testing period of 12 calendar months determined under subdivision 6. In consultation with the county that experienced the unacceptable loss, the commissioner must make appropriate adjustments to base year amounts as needed to prevent the base amounts from being unduly

influenced by onetime events, anomalies, or small changes that appear large compared to a narrow historical base. The commissioner must not make adjustments to the eight county human services agencies that received the greatest amount of targeted case management federal reimbursement during the base calendar years. For agencies other than the eight county human services agencies that received the greatest amount, the total of all adjustments for a given calendar year must not exceed two percent of statewide federal targeted case management federal reimbursement that calendar year.

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

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

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

Sec. 20. Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, is amended to read:

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

(b) Except as provided under paragraph (m), payment for targeted case management provided by county staff under this subdivision ~~shall~~ must be based on the ~~monthly~~ rate ~~methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one combined average rate together with adult mental health case management under section 256B.0625, subdivision 20, except for calendar year 2002. In calendar year 2002, the rate for case management under this section shall be the same as the rate for adult mental health case management in effect as of December 31, 2001~~ established in section 256B.076,

subdivisions 5 and 7. Billing and payment must identify the recipient's primary population group to allow tracking of revenues.

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

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

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

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

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

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

(i) Notwithstanding section 256B.041, county payments for the cost of case management services provided by county staff shall not be made to the commissioner of management and budget. For the purposes of targeted case management services provided by county

staff under this section, the centralized disbursement of payments to counties under section 256B.041 consists only of federal earnings from services provided under this section.

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

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

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

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

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

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

Sec. 21. Minnesota Statutes 2024, section 256B.094, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

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

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

Sec. 22. Minnesota Statutes 2024, section 256B.094, subdivision 3, is amended to read:

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

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

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

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

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

Sec. 23. Minnesota Statutes 2024, section 256B.094, subdivision 6, is amended to read:

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

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

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

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

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

~~(d)~~ (c) Payment for case management provided by county contracted vendors must be calculated in accordance with section 256B.076, subdivision 2. Payment for case management provided by vendors who contract with a Tribe must be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged by the vendor for the same service to other payers. ~~If the service is provided by a team of contracted vendors, the team shall~~

~~determine how to distribute the rate among its members.~~ No reimbursement received by contracted vendors shall be returned to the county or Tribal social services, except to reimburse the county or Tribal social services for advance funding provided by the county or Tribal social services to the vendor.

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

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

Sec. 24. Minnesota Statutes 2024, section 256B.094, subdivision 7, is amended to read:

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

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

(1) in accordance with section 260C.212, subdivision 4a, and United States Code, title 42, section 622(b)(17), there must be a face-to-face contact either in person or by interactive

video that meets the requirements of section 256B.0625, subdivision 20b, at least once a month, except as provided in clause (2); and

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

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

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

(1) the name of the recipient;

(2) the date of the service;

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

(4) the nature and extent of services; and

(5) the place of the services.

Sec. 25. Minnesota Statutes 2024, section 256L.04, subdivision 14, is amended to read:

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

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

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

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

Sec. 26. Minnesota Statutes 2024, section 295.52, subdivision 8, is amended to read:

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

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

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

ARTICLE 4
PROVIDER BRIDGE REIMBURSEMENTS

Section 1. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 13l. **Bridge directed pharmacy dispensing payment.** (a) The commissioner shall provide a directed pharmacy dispensing payment of $2.25 per filled prescription to eligible outpatient retail pharmacies in Minnesota to improve and maintain access to pharmaceutical services in rural and underserved areas of the state. The directed pharmacy dispensing payment is in addition to any other dispensing fee paid by the commissioner to the pharmacy. Filled prescriptions eligible for a directed pharmacy dispensing payment under this subdivision include all prescriptions covered under medical assistance, including fee-for-service and managed care medical assistance.

(b) For purposes of this subdivision, "eligible outpatient retail pharmacy" means an outpatient retail pharmacy licensed under chapter 151 that is not owned, either directly or indirectly or through an affiliate or subsidiary, by a pharmacy benefit manager licensed

under chapter 62W or a health carrier, as defined in section 62A.011, subdivision 2, and that:

(1) is located in a medically underserved area or primarily serves a medically underserved population, as defined by the United States Department of Health and Human Services Health Resources and Services Administration under United States Code, title 42, section 254; or

(2) shares common ownership with 13 or fewer Minnesota pharmacies.

(c) In order to receive the directed pharmacy dispensing payment, a pharmacy must submit to the commissioner a form, developed by the commissioner, attesting that the pharmacy meets the requirements of paragraph (b).

(d) The commissioner shall set and adjust the amount of the directed pharmacy dispensing payment to reflect the available state funding.

(e) The commissioner shall pay the directed pharmacy dispensing payment to eligible outpatient retail pharmacies for eligible pharmacy claims from July 1, 2025, through June 30, 2026, by October 1, 2026. A second payment for eligible claims between July 1, 2026, through December 31, 2026, shall be paid by April 1, 2027.

(f) This subdivision expires on the effective date of Laws 2025, First Special Session chapter 3, article 4, section 8.

Sec. 2. Minnesota Statutes 2025 Supplement, section 256B.69, subdivision 6d, is amended to read:

Subd. 6d. **Prescription drugs.** (a) The commissioner may exclude or modify coverage for prescription drugs from the prepaid managed care contracts entered into under this section in order to increase savings to the state by collecting additional prescription drug rebates.

(b) The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. The contracts must require that the managed care plans enter into contracts with the state's selected pharmacy benefit manager vendor to administer the pharmacy benefit.

(c) This subdivision is contingent on federal approval of the managed care contract changes and the collection of additional prescription drug rebates.

(d) The commissioner must require that, after taking into account any and all transaction fees, data fees, reimbursement reconciliations, effective rate applications, direct or indirect remuneration fees, or other similar constructs, the final reimbursement to a pharmacy from managed care and county-based purchasing plans and any pharmacy benefit managers under contract with these entities be equal to a dispensing fee of $11.55 per claim for prescriptions filled with drugs meeting the definition of covered outpatient drugs. The commissioner must require the payment of a dispensing fee of $3.65 for drugs not meeting the definition of covered outpatient drug.

(e) In addition to the dispensing fee set forth in paragraph (d), the commissioner must require that, after taking into account any and all transaction fees, data fees, reimbursement reconciliations, effective rate applications, direct or indirect remuneration fees, or other similar constructs, the final reimbursement to a pharmacy from managed care and county-based purchasing plans and any pharmacy benefit managers under contract with these entities be equal to the ingredient cost for a drug as either:

(1) the lower of the National Average Drug Acquisition Cost (NADAC) or the Minnesota actual acquisition cost (MNAAC) under section 256B.0625, subdivision 13, paragraph (g);

(2) the maximum allowable cost, if a drug ingredient cost is unreported in the NADAC and the MNAAC; or

(3) the wholesale acquisition cost minus two percent if a drug ingredient cost is unreported in the NADAC and the MNAAC and a maximum allowable cost is unavailable.

(f) The commissioner must monitor the effect of this requirement on access to pharmaceutical services in rural and underserved areas of the state. If, for any contract year, federal approval is not received for this subdivision, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect removal of this subdivision. A contract between a managed care plan or county-based purchasing plan, or any pharmacy benefit manager under contract with one of those entities, and a provider to whom this subdivision 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 subdivision. This subdivision expires if federal approval is not received for this subdivision at any time.

(g) Paragraphs (d) to (g) expire upon the effective date of a master contract under section 256B.696. The commissioner shall notify the revisor of statutes of the effective date.

Sec. 3. Minnesota Statutes 2025 Supplement, section 256B.761, is amended by adding a subdivision to read:

Subd. 5. **Psychological testing and assessment rates.** (a) Effective for services rendered on or after January 1, 2027, or on or after the date of federal approval, whichever is later, and notwithstanding other rate increases or decreases, the commissioner must pay 100 percent of the total published Medicare payment rate, as defined in Code of Federal Regulations, title 42, section 438.6, for the following services:

(1) neuropsychological assessments under section 256B.0671, subdivision 8;

(2) neuropsychological testing under section 256B.0671, subdivision 9; and

(3) psychological testing under section 256B.0671, subdivision 10.

(b) Managed care and county-based purchasing plans must reimburse providers at an amount that is at least equal to the fee-for-service rate for services under this subdivision. The commissioner must monitor the effect of this rate adjustment on enrollee access to mental health services. If for any contract year federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care and county-based purchasing plans for that contract year to reflect the removal of this paragraph. Contracts between managed care 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 paragraph.

(c) This subdivision expires on the effective date of Laws 2025, First Special Session chapter 3, article 8, section 29.

Sec. 4. **REPEALER.**

Minnesota Statutes 2024, section 256B.0625, subdivision 38, is repealed.

ARTICLE 5
CHILDREN, YOUTH, AND FAMILIES

Section 1. Minnesota Statutes 2025 Supplement, section 142A.03, subdivision 2, is amended to read:

Subd. 2. **Duties of the commissioner.** (a) The commissioner may apply for and accept on behalf of the state any grants, bequests, gifts, or contributions for the purpose of carrying out the duties and responsibilities of the commissioner. Any money received under this

paragraph is appropriated and dedicated for the purpose for which the money is granted. The commissioner must biennially report to the chairs and ranking minority members of relevant legislative committees and divisions by January 15 of each even-numbered year a list of all grants and gifts received under this subdivision.

(b) Pursuant to law, the commissioner may apply for and receive money made available from federal sources for the purpose of carrying out the duties and responsibilities of the commissioner.

(c) The commissioner may make contracts with and grants to Tribal Nations, public and private agencies, for-profit and nonprofit organizations, and individuals using appropriated money.

(d) The commissioner must develop program objectives and performance measures for evaluating progress toward achieving the objectives. The commissioner must identify the objectives, performance measures, and current status of achieving the measures in a biennial report to the chairs and ranking minority members of relevant legislative committees and divisions. The report is due no later than January 15 each even-numbered year. The report must include, when possible, the following objectives:

(1) centering and including the lived experiences of children and youth, including those with disabilities and mental illness and their families, in all aspects of the department's work;

(2) increasing the effectiveness of the department's programs in addressing the needs of children and youth facing racial, economic, or geographic inequities;

(3) increasing coordination and reducing inefficiencies among the department's programs and the funding sources that support the programs;

(4) increasing the alignment and coordination of family access to child care and early learning programs and improving systems of support for early childhood and learning providers and services;

(5) improving the connection between the department's programs and the kindergarten through grade 12 and higher education systems; and

(6) minimizing and streamlining the effort required of youth and families to receive services to which the youth and families are entitled.

(e) The commissioner ~~shall~~ must administer and supervise the forms of public assistance and other activities or services that are vested in the commissioner. Administration and supervision of activities or services includes but is not limited to assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In

addition to administering and supervising activities vested by law in the department, the commissioner has the authority to:

(1) require county agency participation in training and technical assistance programs to promote compliance with statutes, rules, federal laws, regulations, and policies governing the programs and activities administered by the commissioner;

(2) monitor, on an ongoing basis, the performance of county agencies in the operation and administration of activities and programs; enforce compliance with statutes, rules, federal laws, regulations, and policies governing welfare services; and promote excellence of administration and program operation;

(3) develop a quality control program or other monitoring program to review county performance and accuracy of benefit determinations;

(4) require county agencies to make an adjustment to the public assistance benefits issued to any individual consistent with federal law and regulation and state law and rule and to issue or recover benefits as appropriate;

(5) delay or deny payment of all or part of the state and federal share of benefits and administrative reimbursement according to the procedures set forth in section 142A.10;

(6) make contracts with and grants to public and private agencies and organizations, both for-profit and nonprofit, and individuals, using appropriated funds; and

(7) enter into contractual agreements with federally recognized Indian Tribes with a reservation in Minnesota to the extent necessary for the Tribe to operate a federally approved family assistance program or any other program under the supervision of the commissioner. The commissioner ~~shall~~ must consult with the affected county or counties in the contractual agreement negotiations, if the county or counties wish to be included, in order to avoid the duplication of county and Tribal assistance program services. The commissioner may establish necessary accounts for the purposes of receiving and disbursing funds as necessary for the operation of the programs.

The commissioner ~~shall~~ must work in conjunction with the commissioner of human services to carry out the duties of this paragraph when necessary and feasible.

(f) The commissioner ~~shall~~ must inform county agencies, on a timely basis, of changes in statute, rule, federal law, regulation, and policy necessary to county agency administration of the programs and activities administered by the commissioner.

(g) The commissioner ~~shall~~ must administer and supervise child welfare activities, including promoting the enforcement of laws preventing child maltreatment and protecting

children with a disability and children who are in need of protection or services, licensing and supervising child care and child-placing agencies, and supervising the care of children in foster care. The commissioner ~~shall~~ must coordinate with the commissioner of human services on activities impacting children overseen by the Department of Human Services, such as disability services, behavioral health, and substance use disorder treatment.

(h) The commissioner ~~shall~~ must assist and cooperate with local, state, and federal departments, agencies, and institutions.

(i) The commissioner ~~shall~~ must establish and maintain any administrative units reasonably necessary for the performance of administrative functions common to all divisions of the department.

(j) The commissioner ~~shall~~ must act as designated guardian of children pursuant to chapter 260C. For children under the guardianship of the commissioner or a Tribe in Minnesota recognized by the Secretary of the Interior whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota Tribal social services agency to provide adoption services. For children in out-of-home care whose interests would be best served by a transfer of permanent legal and physical custody to a relative under section 260C.515, subdivision 4, or equivalent in Tribal code, the commissioner may contract with a licensed child-placing agency or a Minnesota Tribal social services agency to provide permanency services. A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing county programs or Tribal social services, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative, Tribal governing body, or the commissioner has evidence that child placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child ~~shall~~ must remain available until the terms of the agreement are fulfilled or the agreement is terminated.

(k) The commissioner has the authority to conduct and administer experimental projects to test methods and procedures of administering assistance and services to recipients or potential recipients of public benefits. To carry out the experimental projects, the commissioner may waive the enforcement of existing specific statutory program requirements, rules, and standards in one or more counties. The order establishing the waiver must provide alternative methods and procedures of administration and must not conflict with the basic purposes, coverage, or benefits provided by law. ~~No~~ A project under this paragraph ~~shall~~ must not exceed four years. No order establishing an experimental project as authorized by this paragraph is effective until the following conditions have been met:

(1) the United States Secretary of Health and Human Services has agreed, for the same project, to waive state plan requirements relative to statewide uniformity; and

(2) a comprehensive plan, including estimated project costs, has been approved by the Legislative Advisory Commission and filed with the commissioner of administration.

(l) The commissioner ~~shall~~ must, according to federal requirements and in coordination with the commissioner of human services, establish procedures to be followed by local welfare boards in creating citizen advisory committees, including procedures for selection of committee members.

(m) The commissioner ~~shall~~ must allocate federal fiscal disallowances or sanctions that are based on quality control error rates under United States Code, title 7, section 2025(c), for ~~the aid to families with dependent children (AFDC) program formerly codified in sections 256.72 to 256.87 or~~ the Supplemental Nutrition Assistance Program (SNAP) in the following manner:

(1) one-half of the total amount of the disallowance shall be borne by the county boards responsible for administering the programs. ~~For AFDC, disallowances shall be shared by each county board in the same proportion as that county's expenditures to the total of all counties' expenditures for AFDC. For SNAP,~~ Sanctions ~~shall~~ must be shared by each county board, with 50 percent of the sanction being distributed to each county in the same proportion as that county's administrative costs for SNAP benefits are to the total of all SNAP administrative costs for all counties, and 50 percent of the sanctions being distributed to each county in the same proportion as that county's value of SNAP benefits issued are to the total of all benefits issued for all counties. Each county ~~shall~~ must pay its share of the disallowance to the state of Minnesota. When a county fails to pay the amount due under this paragraph, the commissioner may deduct the amount from reimbursement otherwise due the county, or the attorney general, upon the request of the commissioner, may institute civil action to recover the amount due; ~~and~~

(2) notwithstanding the provisions of clause (1), if the disallowance results from knowing noncompliance by one or more counties with a specific program instruction, and that knowing noncompliance is a matter of official county board record, the commissioner may require payment or recover from the county or counties, in the manner prescribed in clause (1), an amount equal to the portion of the total disallowance that resulted from the noncompliance and may distribute the balance of the disallowance according to clause (1)~~.~~; and

(3) the commissioner's allocation requirements under this paragraph must not apply to the state share of SNAP benefit costs under section 142F.05, subdivision 5.

(n) The commissioner ~~shall~~ must develop and implement special projects that maximize reimbursements and result in the recovery of money to the state. For the purpose of recovering state money, the commissioner may enter into contracts with third parties. Any recoveries that result from projects or contracts entered into under this paragraph ~~shall~~ must be deposited in the state treasury and credited to a special account until the balance in the account reaches $1,000,000. When the balance in the account exceeds $1,000,000, the excess ~~shall~~ must be transferred and credited to the general fund. All money in the account is appropriated to the commissioner for the purposes of this paragraph.

(o) The commissioner has the authority to establish and enforce the following county reporting requirements:

(1) the commissioner ~~shall~~ must establish fiscal and statistical reporting requirements necessary to account for the expenditure of funds allocated to counties for programs administered by the commissioner. When establishing financial and statistical reporting requirements, the commissioner ~~shall~~ must evaluate all reports, in consultation with the counties, to determine if the reports can be simplified or the number of reports can be reduced;

(2) the county board ~~shall~~ must submit monthly or quarterly reports to the department as required by the commissioner. Monthly reports are due no later than 15 working days after the end of the month. Quarterly reports are due no later than 30 calendar days after the end of the quarter, unless the commissioner determines that the deadline must be shortened to 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss of federal funding. Only reports that are complete, legible, and in the required format ~~shall~~ must be accepted by the commissioner;

(3) if the required reports are not received by the deadlines established in clause (2), the commissioner may delay payments and withhold funds from the county board until the next reporting period. When the report is needed to account for the use of federal funds and the late report results in a reduction in federal funding, the commissioner ~~shall~~ must withhold from the county boards with late reports an amount equal to the reduction in federal funding until full federal funding is received;

(4) a county board that submits reports that are late, illegible, incomplete, or not in the required format for two out of three consecutive reporting periods is considered noncompliant. When a county board is found to be noncompliant, the commissioner ~~shall~~ must notify the county board of the reason the county board is considered noncompliant and request that the county board develop a corrective action plan stating how the county

board plans to correct the problem. The corrective action plan must be submitted to the commissioner within 45 days after the date the county board received notice of noncompliance;

(5) the final deadline for fiscal reports or amendments to fiscal reports is one year after the date the report was originally due. If the commissioner does not receive a report by the final deadline, the county board forfeits the funding associated with the report for that reporting period and the county board must repay any funds associated with the report received for that reporting period;

(6) the commissioner may not delay payments, withhold funds, or require repayment under clause (3) or (5) if the county demonstrates that the commissioner failed to provide appropriate forms, guidelines, and technical assistance to enable the county to comply with the requirements. If the county board disagrees with an action taken by the commissioner under clause (3) or (5), the county board may appeal the action according to sections 14.57 to 14.69; and

(7) counties subject to withholding of funds under clause (3) or forfeiture or repayment of funds under clause (5) ~~shall~~ must not reduce or withhold benefits or services to clients to cover costs incurred due to actions taken by the commissioner under clause (3) or (5).

(p) The commissioner ~~shall~~ must allocate federal fiscal disallowances or sanctions for audit exceptions when federal fiscal disallowances or sanctions are based on a statewide random sample in direct proportion to each county's claim for that period.

(q) The commissioner is responsible for ensuring the detection, prevention, investigation, and resolution of fraudulent activities or behavior by applicants, recipients, and other participants in the programs administered by the department. The commissioner ~~shall~~ must cooperate with the commissioner of education to enforce the requirements for program integrity and fraud prevention for investigation for child care assistance under chapter 142E.

(r) The commissioner ~~shall~~ must require county agencies to identify overpayments, establish claims, and utilize all available and cost-beneficial methodologies to collect and recover these overpayments in the programs administered by the department.

(s) The commissioner ~~shall~~ must develop recommended standards for child foster care homes that address the components of specialized therapeutic services to be provided by child foster care homes with those services.

(t) The commissioner ~~shall~~ must authorize the method of payment to or from the department as part of the programs administered by the department. This authorization

includes the receipt or disbursement of funds held by the department in a fiduciary capacity as part of the programs administered by the department.

(u) In coordination with the commissioner of human services, the commissioner ~~shall~~ must create and provide county and Tribal agencies with blank applications, affidavits, and other forms as necessary for public assistance programs.

(v) The commissioner ~~shall~~ must cooperate with the federal government and its public welfare agencies in any reasonable manner as may be necessary to qualify for federal aid for temporary assistance for needy families and in conformity with Title I of Public Law 104-193, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 and successor amendments, including making reports that contain information required by the federal Social Security Advisory Board and complying with any provisions the board may find necessary to assure the correctness and verification of the reports.

(w) On or before January 15 in each even-numbered year, the commissioner ~~shall~~ must make a biennial report to the governor concerning the activities of the agency.

(x) The commissioner ~~shall~~ must enter into agreements with other departments of the state as necessary to meet all requirements of the federal government.

(y) The commissioner may cooperate with other state agencies in establishing reciprocal agreements in instances where a child receiving Minnesota family investment program (MFIP) assistance or its out-of-state equivalent moves or contemplates moving into or out of the state, in order that the child may continue to receive MFIP or equivalent aid from the state moved from until the child has resided for one year in the state moved to.

(z) The commissioner ~~shall~~ must provide appropriate technical assistance to county agencies to develop methods to have county financial workers remind and encourage recipients of aid to families with dependent children, the Minnesota family investment program, the Minnesota family investment plan, family general assistance, or SNAP benefits whose assistance unit includes at least one child under the age of five to have each young child immunized against childhood diseases. The commissioner must examine the feasibility of utilizing the capacity of a statewide computer system to assist county agency financial workers in performing this function at appropriate intervals.

(aa) The commissioner ~~shall~~ must have the power and authority to accept on behalf of the state contributions and gifts for the use and benefit of children under the guardianship or custody of the commissioner. The commissioner may also receive and accept on behalf of such children money due and payable to them as old age and survivors insurance benefits, veterans benefits, pensions, or other such monetary benefits. Gifts, contributions, pensions,

and benefits under this paragraph must be deposited in and disbursed from the social welfare fund provided for in sections 256.88 to 256.92.

(bb) The specific enumeration of powers and duties in this section must not be construed to be a limitation upon the general powers granted to the commissioner.

Sec. 2. **[142D.095] PRESCHOOL ASSESSMENT.**

(a) For programs serving children under section 142D.08, the commissioner of children, youth, and families must implement a preschool assessment of children's development in the year prior to kindergarten entry that is:

(1) aligned to the state early childhood indicators of progress and based on the criteria to be an early learning assessment approved by the commissioner; and

(2) based, in part, on information collected from teachers, early learning professionals, families, and other partners.

(b) School districts and charter schools serving children in a program under section 142D.08 must choose a commissioner-approved assessment tool under paragraph (a).

(c) The commissioner may provide technical assistance and professional development related to the assessment to educators, school districts, and charter schools.

Sec. 3. Minnesota Statutes 2024, section 142D.21, subdivision 3, is amended to read:

Subd. 3. **Requirements.** (a) As a condition of payment under this section, a program must:

(1) complete an application developed by the commissioner for each payment period for which the program applies for funding. For full-time equivalent staff who regularly care for children in the program, the application must allow required paid break time to count as qualifying hours toward a program's reporting of eligible full-time equivalent staff;

(2) submit data on child enrollment and attendance to the commissioner in the form and manner specified by the commissioner; and

(3) attest and agree in writing that the program was open and operating and served a minimum number of children, as determined by the commissioner, during the funding period, with the exceptions of:

(i) service disruptions that are necessary to protect the safety and health of children and child care programs based on public health guidance issued by the Centers for Disease

Control and Prevention, the commissioner of health, the commissioner of children, youth, and families, or a local public health agency; and

(ii) planned temporary closures for provider vacation and holidays during each payment period. The commissioner must establish the maximum allowed duration for vacations and holidays.

(b) A program must expend money received under this section no later than six months after the date the payment was received.

(c) A program that receives a payment under this section must comply with all requirements listed in the application. The commissioner must establish methods to determine that the application requirements have been met.

Sec. 4. Minnesota Statutes 2024, section 142F.05, is amended by adding a subdivision to read:

Subd. 5. **State share of SNAP benefit costs.** The commissioner of children, youth, and families must pay the state share of SNAP benefit costs as determined by the United States Department of Agriculture to meet the state cost share requirements under United States Code, title 7, section 2013(a)(2)(B).

Sec. 5. Minnesota Statutes 2024, section 142F.05, is amended by adding a subdivision to read:

Subd. 6. **County administrative cost share limitation.** (a) A county agency must not contribute more than 50 percent of the total administrative costs of SNAP. The commissioner must reimburse each county agency for the difference between the federal reimbursement of administrative costs and the county administrative cost share under this subdivision.

(b) SNAP administrative costs eligible for reimbursement under this subdivision are administrative costs as defined under United States Code, title 7, section 2025(a).

Sec. 6. Minnesota Statutes 2024, section 256.017, subdivision 2, is amended to read:

Subd. 2. **Definitions.** The following terms have the meanings given for purposes of this section.

(a) "Administrative penalty" means an adjustment against the county agency's state and federal benefit and federal administrative reimbursement when the commissioner determines that the county agency is not in compliance with the policies and procedures established by the commissioner.

(b) "Commissioner" means the commissioner of human services for programs listed in subdivision 1, paragraph ~~(b)~~ (a), and the commissioner of children, youth, and families for programs listed in subdivision 1, paragraph ~~(c)~~ (b).

(c) "Quality control case penalty" means an adjustment against the county agency's federal administrative reimbursement and state and federal benefit reimbursement when the commissioner determines through a quality control review that the county agency has made incorrect payments, terminations, or denials of benefits as determined by state quality control procedures for the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, Minnesota family investment program, SNAP, or medical assistance programs, or any other programs for which the commissioner has developed a quality control system. Quality control case penalties apply only to agency errors as defined by state quality control procedures.

(d) "Quality control/quality assurance" means a review system of a statewide random sample of cases, designed to provide data on program outcomes and the accuracy with which state and federal policies are being applied in issuing benefits and as a fiscal audit to ensure the accuracy of expenditures. The quality control/quality assurance system is administered by the department. For the aid to families with dependent children program formerly codified in sections 256.72 to 256.87, SNAP, and medical assistance, the quality control system is that required by federal regulation, or those developed by the commissioner.

Sec. 7. **PREPARED MEALS FOOD RELIEF GRANTS.**

Subdivision 1. **Establishment** The commissioner of children, youth, and families must establish a prepared meals grant program to provide hunger relief to Minnesotans experiencing food insecurity and who have difficulty preparing meals due to limited mobility, disability, or limited resources.

Subd. 2. **Eligible grantees.** (a) Eligible grantees are nonprofit organizations and Minnesota Tribal governments, as defined in Minnesota Statutes, section 10.65, with a demonstrated history of providing and distributing prepared meals customized for the population that they serve, including tailoring meals to cultural, religious, and dietary needs. Eligible grantees must prepare meals in a licensed commercial kitchen and distribute meals according to ServSafe guidelines.

(b) An individual or nonprofit organization affiliated with Feeding Our Future is prohibited from receiving grant funds under this section.

Subd. 3. **Application.** Applicants for grant funds under this section must apply to the commissioner on the forms and in the time and manner established by the commissioner.

Subd. 4. **Allowable uses of grant funds.** Eligible grantees must use grant funds awarded under this section to fund a prepared meals program that primarily targets individuals 18 years of age or older and under 61 years of age, and their dependents experiencing food insecurity. Grantees must not receive funding from other state and federal meal programs for activities funded under this section.

Subd. 5. **Duties of the commissioner.** (a) The commissioner must develop a process for determining eligible grantees under this section.

(b) When awarding grants under this section, the commissioner must prioritize applicants that:

(1) have demonstrated the ability to provide prepared meals to racially, ethnically, and geographically diverse populations at greater risk for food insecurity;

(2) work with external community partners to distribute meals targeting nontraditional meal sites reaching those most in need; and

(3) have a demonstrated history of sourcing at least 50 percent of the prepared meal ingredients from:

(i) Minnesota food producers and processors; or

(ii) food that is donated or would otherwise be waste.

(c) The commissioner must consider geographic distribution to ensure statewide coverage when awarding grants and minimize the number of grantees to simplify administrative burdens and costs.

Subd. 6. **Reporting.** (a) Grantees must retain records documenting expenditure of the money and comply with any additional documentation requirements imposed by the commissioner.

(b) Grantees must report on the use of grant funds received under this section to the commissioner. The commissioner must determine the timing and form required for the reports.

(c) If the commissioner determines that ineligible expenditures were made by a grantee under this section, the ineligible amount must be repaid by the grantee to the commissioner and deposited in the general fund.

Sec. 8. **REGIONAL FOOD BANK GRANTS.**

Subdivision 1. **Establishment.** The commissioner of children, youth, and families must establish regional food bank grants to increase the availability of food to individuals and families in need.

Subd. 2. **Distribution of appropriation.** The commissioner must distribute funds appropriated under this section to regional food banks and Minnesota Tribal governments, as defined in Minnesota Statutes, section 10.65, using a formula based on the number of persons in households having incomes below the federal poverty level and the number of unemployed persons in the service area of the food bank or Minnesota Tribal government.

Subd. 3. **Allowable use of funds.** (a) Grant funds distributed under this section must be used to purchase, transport, and coordinate the distribution of food to sites approved by the commissioner. Grant funds distributed under this section may also be used to purchase personal hygiene products, including but not limited to diapers and toilet paper.

(b) Food and other allowable products purchased with grant funds under this section must be available at no cost at sites approved by the commissioner.

(c) Grant funds distributed under this section must not be used for the compensation of officers, directors, trustees, key employees, and highest compensated employees as reported on Internal Revenue Service Form 990.

Subd. 4. **Reporting.** (a) Food banks and Minnesota Tribal governments receiving grant funds under this section must retain records documenting expenditures of the grant funds and comply with any additional documentation requirements imposed by the commissioner.

(b) Food banks and Minnesota Tribal governments must report on the use of grant funds received under this section to the commissioner. The commissioner must determine the timing and form required for the reports.

Subd. 5. **Ineligible expenditures.** If the commissioner determines that ineligible expenditures were made by a food bank or Minnesota Tribal government under this section, the ineligible amount must be repaid by the food bank or Tribal government to the commissioner and deposited in the general fund.

ARTICLE 6

CHILD CARE CENTER LICENSING MODERNIZATION

Section 1. **[142H.01] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of this chapter, the terms in this section have the meanings given.

Subd. 2. **Accessible to children.** "Accessible to children" means capable of being reached or utilized by a child without the aid of an adult.

Subd. 3. **Accredited.** "Accredited" means a postsecondary institution or technical college recognized and listed in The Database of Accredited Postsecondary Institutions and Programs maintained by the United States Department of Education.

Subd. 4. **Age categories.** (a) "Infant" means a child who is at least six weeks old but less than 16 months old.

(b) "Toddler" means a child who is at least 16 months old but less than 33 months old.

(c) "Preschooler" means a child who is at least 33 months old up to school age.

(d) "School age" means a child who is at least of sufficient age to have attended the first day of kindergarten, or is eligible to enter kindergarten within the next four months, but is younger than 13 years of age. A child who becomes 13 during the school year may continue to be considered a school-age child for the remainder of the school year.

Subd. 5. **Applicant.** "Applicant" has the meaning given in section 142B.01, subdivision 4.

Subd. 6. **Arrival and departure times.** "Arrival and departure times" means the times when children typically arrive at or depart from a center. A center cannot designate more than 25 percent of licensed hours of operation as arrival and departure times. The designated arrival and departure times must be used at the beginning or end of a center's licensed hours of operation.

Subd. 7. **Building official.** "Building official" means the person appointed pursuant to section 326B.133 to administer the State Building Code or the building official's authorized representative.

Subd. 8. **Center.** "Center" means a child care program that is not excluded by section 142B.05, subdivision 2, and is not a family child care program, as defined in section 142I.01, subdivision 22.

Subd. 9. **Child.** "Child" means a person receiving child care services who falls within the age categories in subdivision 4.

Subd. 10. **Child care program.** "Child care program" means the organization or arrangement of activities, personnel, materials, and equipment in a facility to promote the physical, intellectual, social, and emotional development of a child in the absence of the parent for a period of less than 24 hours a day.

Subd. 11. **Child care program plan.** "Child care program plan" means the written document that states specific activities that will be provided by the license holder to promote the physical, intellectual, social, and emotional development of the children enrolled in the center.

Subd. 12. **Clean.** "Clean" means free from dirt or other contaminants that can be detected by sight, smell, or touch.

Subd. 13. **Commissioner.** "Commissioner" means the commissioner of children, youth, and families.

Subd. 14. **Day program.** "Day program" means a nonresidential child care program that operates during waking hours and does not provide overnight care.

Subd. 15. **Department.** "Department" means the Department of Children, Youth, and Families.

Subd. 16. **Direct contact.** "Direct contact" has the meaning given in section 245C.02, subdivision 11.

Subd. 17. **Disinfected.** "Disinfected" means the chemical process to kill most germs and viruses on surfaces and objects after they have been cleaned.

Subd. 18. **Drop-in child care program.** "Drop-in child care program" means a nonresidential program of child care in which children participate on a onetime only or occasional basis up to a maximum of 90 hours per child, per month.

Subd. 19. **Experience.** "Experience" means paid or unpaid employment:

(1) caring for children as a teacher, assistant teacher, aide, or student intern:

(i) in a licensed child care center, a licensed family child care program, or a Tribally licensed child care program in any United States state or territory; or

(ii) in a public or nonpublic school;

(2) caring for children as a staff person or unsupervised volunteer in a certified license-exempt child care center under chapter 142C; or

(3) providing direct contact services in a home or residential facility serving children with disabilities that requires a background study under section 245C.03.

Subd. 20. **Facility.** "Facility" means the indoor and outdoor space where a child care program is provided.

Subd. 21. **Fire marshal.** "Fire marshal" means the person designated by section 299F.011 to administer and enforce the State Fire Code or the fire marshal's authorized representative.

Subd. 22. **Health care provider.** "Health care provider" means a physician or physician's assistant licensed to practice medicine under chapter 147 or an advanced practice registered nurse licensed under chapter 148.

Subd. 23. **Health consultant.** "Health consultant" means a registered nurse, a public health nurse, or a health care provider as defined in subdivision 22 who performs health consultation services for a child care center pursuant to section 142H.29, subdivision 2.

Subd. 24. **Inaccessible to children.** "Inaccessible to children" means not capable of being reached or utilized by a child without the aid of an adult.

Subd. 25. **License.** "License" has the meaning given in section 142B.01, subdivision 16.

Subd. 26. **License holder.** "License holder" has the meaning given in section 142B.01, subdivision 17.

Subd. 27. **Licensed capacity.** "Licensed capacity" means the maximum number of children permitted at any one time in the program for which the license holder is licensed to operate.

Subd. 28. **Medication.** "Medication" means any substance or preparation that is used to prevent or treat a wound, injury, infection, and disease; maintain health; heal; or relieve pain. This includes medication that is over the counter, or prescribed by a physician, physician assistant, dentist, or advance practice registered nurse certified to prescribe medication, and permitted by the parent for administration or application. This term applies to medication taken internally or applied externally.

Subd. 29. **Night care program.** "Night care program" means a nonresidential child care program that provides overnight care to children during sleeping hours, approximately 11:00 p.m. to 5:00 a.m. Night care programs are subject to the requirements in section 142H.16.

Subd. 30. **Parent.** "Parent" means the person or persons who has the legal responsibility for a child such as the child's mother, father, or legally appointed guardian.

Subd. 31. **Program staff person.** "Program staff person" means an employee of the child care center who carries out the child care program plan and has direct contact with children. This includes unsupervised volunteers and substitutes.

Subd. 32. **Sick care program.** "Sick care program" means a nonresidential child care program that exclusively cares for sick children. Sick care programs are subject to the requirements in section 142H.19.

Subd. 33. **Staff supervision.** "Staff supervision" means responsibility to hire, train, assign duties, and direct staff in day-to-day activities and evaluate staff performance. A "supervisor" is a person with staff supervision responsibility.

Subd. 34. **State Building Code.** "State Building Code" means the codes and regulations adopted by the commissioner of the administration according to section 326B.101, and contained in Minnesota Rules, chapter 1300.

Subd. 35. **State Fire Code.** "State Fire Code" means the codes and regulations adopted by the state fire marshal pursuant to section 299F.011, and contained in Minnesota Rules, chapter 7511.

Subd. 36. **Student intern.** "Student intern" means a student of a postsecondary institution assigned by that institution for a supervised experience with children. The experience must be in a licensed center, an elementary school operated by the commissioner of education or a legally constituted local school board, or a private school approved under rules administered by the commissioner of education. Student intern includes a person who is practice teaching, student teaching, or carrying out a practicum or internship.

Subd. 37. **Substitute.** "Substitute" means a person who is temporarily filling a position as a director, teacher, assistant teacher, or aide in a licensed child care center for less than 500 hours total in a calendar year due to the absence of a regularly employed program staff person.

Subd. 38. **Supervision of children.** "Supervision of children" means when a program staff person:

(1) is accountable for the child's care;

(2) is able to intervene to protect the health and safety of the child; and

(3) is within sight and hearing of the child at all times, except as described in section 142H.24, subdivision 1.

Subd. 39. **Variance.** "Variance" means written permission by the commissioner for a license holder or applicant to depart from the provisions of a requirement in this chapter pursuant to section 142B.10, subdivision 16.

Subd. 40. **Volunteer.** (a) "Volunteer" means an individual who assists in the care of a child and is not employed by the child care center.

(b) "Supervised volunteer" means a volunteer who may only have direct contact with children when a program staff person is able to intervene to protect the health and safety of children.

(c) "Unsupervised volunteer" means a volunteer who may have direct contact with children without a program staff person present, must receive the training required under section 142H.08, and may be counted in the staff-to-child ratios under section 142H.10.

Sec. 2. **[142H.02] APPLICABILITY AND LICENSING PROCESS.**

(a) No child care center may operate in Minnesota without a license pursuant to this chapter and chapter 142B. An applicant for a license and the license holder is governed by, and must comply with, the general requirements in this chapter and chapters 142B, 245C, and 260E.

(b) The department may grant variances to the requirements in this chapter if the conditions in section 142B.10, subdivision 16, are met.

Sec. 3. **[142H.03] OPERATING OPTIONS.**

A license holder must operate a day program, drop-in child care program, night care program, sick child care program, or a combination of two or more kinds of programs.

Sec. 4. **[142H.04] POLICIES AND PROCEDURES FOR PROGRAM ADMINISTRATION.**

(a) The license holder must maintain and enforce program policies and procedures necessary to comply with licensing requirements under Minnesota Statutes and Minnesota Rules.

(b) The license holder must:

(1) provide training to employees and volunteers related to their duties in implementing the program's policies and procedures developed under paragraph (a);

(2) document the provision of this training; and

(3) monitor implementation of policies and procedures by employees and volunteers.

(c) The license holder must keep program policies and procedures readily accessible to employees and volunteers and index the policies and procedures with a table of contents or another method approved by the commissioner.

Sec. 5. **[142H.05] DIRECTORS.**

Subdivision 1. **General requirements for a director.** (a) A center must have a director who is responsible for overseeing implementation of written policies relating to the management and control of the daily activities of the program, ensuring the health and safety of program participants, and supervising staff and volunteers.

(b) A director must:

(1) be at least 21 years old;

(2) be a graduate of a high school or hold an equivalent diploma attained through successful completion of the commissioner of education-selected high school equivalency test pursuant to section 124D.549;

(3) have at least 1,040 hours of paid or unpaid staff supervision experience; and

(4) have at least 12 semester credits in accredited coursework in postsecondary child development education, supervision, management, administration, or leadership or 120 hours of training earned in the topics of child development, supervision, management, administration, or leadership.

(c) Paragraph (b), clauses (3) and (4), are satisfied if an individual has completed a Minnesota Association for the Education of Young Children early childhood director's credential; Child Care Aware Minnesota director's credential; Montessori administrator credential; or diploma issued by the American Montessori Society, Association Montessori International, or an institution accredited by the Montessori Accreditation Council for Teacher Education.

Subd. 2. **Director or designee on site.** (a) The director or a designee must be on site while the center is in operation.

(b) Any program staff person who is at least 18 years old may serve as the designee. The designee does not have to meet the director qualifications in subdivision 1 but must be aware of the designation and be able to perform the responsibilities.

Subd. 3. **Director functioning as a teacher.** Notwithstanding section 142H.06, a director may be used as a teacher in any classroom as needed.

Subd. 4. **Incumbent director recognition.** Notwithstanding subdivision 1, an individual who is designated as the director of a licensed child care center on July 1, 2027, meets the director qualification requirements of this section as long as the individual continues to work at the program.

Sec. 6. **[142H.06] TEACHERS.**

Subdivision 1. **Teacher general qualifications.** A teacher must:

(1) be at least 18 years old; and

(2) be a graduate of a high school or hold an equivalent diploma attained through successful completion of the commissioner of education-selected high school equivalency test pursuant to section 124D.549.

Subd. 2. **Teacher education and experience requirements.** In addition to the general requirements in subdivision 1, a teacher must have at least one of:

(1) 12 postsecondary semester credits and 480 hours of experience;

(2) 100 hours of commissioner-approved training within the previous five years and 480 hours of experience. After initial qualification, a teacher qualified under this clause must fulfill at least 50 percent of in-service training requirements under section 142H.09, subdivision 10, with commissioner-approved trainings;

(3) a credential or diploma from the American Montessori Society, Association Montessori International, or an institution accredited by the Montessori Accreditation Council for Teacher Education;

(4) an accredited certificate in child development or early childhood education from a postsecondary institution;

(5) an accredited diploma, associate's degree, or bachelor's degree in child development or early childhood education from a postsecondary institution; or

(6) a Child Development Associate (CDA) credential;

Sec. 7. **[142H.07] ASSISTANT TEACHERS.**

Subdivision 1. **Assistant teacher general qualifications.** An assistant teacher must work under the supervision of a teacher and be:

(1) at least 18 years old; and

(2) a graduate of a high school or hold an equivalent diploma attained through successful completion of the commissioner of education-selected high school equivalency test.

Subd. 2. **Assistant teacher education and experience requirements.** In addition to the general requirements in subdivision 1, an assistant teacher must have at least one of:

(1) at least six postsecondary semester credits;

(2) at least 50 hours of commissioner-approved training within the previous five years. After initial qualification, an assistant teacher qualified under this clause must fulfill at least 50 percent of in-service training requirements under section 142H.09, subdivision 10, with commissioner-approved trainings; or

(3) at least 160 hours of experience and be making progress toward any of the teacher qualifications in section 142H.06, subdivision 2, clauses (3) to (6). An assistant teacher qualified under this clause must be able to provide:

(i) documentation of current enrollment; and

(ii) evidence of working toward the successful completion of the credential.

Sec. 8. **[142H.08] AIDES, VOLUNTEERS, AND SUBSTITUTES.**

Subdivision 1. **Aide qualifications.** (a) An aide must work under the supervision of a teacher or assistant teacher, except when performing the tasks in paragraph (b). An aide must be used pursuant to the staff distribution requirements in section 142H.10, subdivision 2.

(b) An aide may work without being supervised by a teacher or assistant teacher when they are assisting with the supervision of sleeping children; assisting children with washing, toileting, and diapering; or accompanying children to and from the bus stop.

(c) An aide must be at least 16 years old.

Subd. 2. **Volunteers.** (a) A volunteer may work as a teacher, assistant teacher, aide, or substitute if the volunteer meets the requirements of that position.

(b) The license holder must maintain a list of all volunteers with relevant information, including first and last name, whether the volunteer must be supervised at all times or may occasionally be unsupervised, and the first date of direct contact with children.

(c) Unsupervised volunteers must successfully complete training as required in section 142H.09.

(d) Supervised volunteers must successfully complete the training required in section 142H.09, subdivision 7.

Subd. 3. **Substitutes.** (a) A substitute must either meet the requirements for the assigned staff position or be designated as an unqualified substitute by the director or the director designee. A director or director designee can designate a substitute as unqualified if:

(1) a teacher is continuously on site, except as provided in section 142H.10, subdivision 2, paragraph (e);

(2) when substituting as a teacher or assistant teacher, the unqualified substitute is aware of the unqualified substitute's designated staffing position; and

(3) the unqualified substitute is at least 18 years of age.

(b) All substitutes must successfully complete the required training under section 142H.09.

Subd. 4. **Tracking unqualified substitute hours.** (a) The license holder must document the use of unqualified substitute hours on the day the unqualified substitute works.

(b) In a calendar year, a license holder must not use unqualified substitutes more than 60 hours multiplied by the number of the center's classrooms.

(c) A license holder must maintain a log of the use of unqualified substitutes in the center administrative record for review by the commissioner. The log must be on a form prescribed by the commissioner.

Sec. 9. **[142H.09] STAFF ORIENTATION AND TRAINING.**

Subdivision 1. **Orientation training.** (a) Program staff persons must complete orientation training before providing direct contact services to a child.

(b) The orientation training must include the following topics:

(1) abusive head trauma for staff working with a child under school age pursuant to subdivision 8;

(2) the center's policy on administration of medication pursuant to section 142H.29, subdivision 5;

(3) the center's policy on allergy prevention and response pursuant to section 142H.15, subdivision 5;

(4) the center's policy on behavior guidance pursuant to section 142H.13;

(5) child passenger restraint systems pursuant to subdivision 9;

(6) the center's child care program plan pursuant to section 142H.11;

(7) the center's policy on cleaning, sanitizing, and disinfecting pursuant to section 142H.31;

(8) the center's emergency preparedness plan and procedures pursuant to section 142H.23, subdivision 1;

(9) procedures for the handling and disposal of bodily fluids pursuant to section 142H.29, subdivision 10;

(10) the center's emergency and accident policies pursuant to section 142H.23, subdivision 2;

(11) the center's health policies pursuant to section 142H.29;

(12) individual child care program plan or plans pursuant to section 142H.15, if applicable;

(13) job responsibilities specific to the individual's position at the center;

(14) prevention and control of infectious diseases pursuant to section 142H.18;

(15) the center's policy on research, cameras, and social media participation procedures pursuant to section 142H.22;

(16) the center's policy on the use of alcohol, drugs, and tobacco products pursuant to section 142B.10, subdivision 1, paragraph (c);

(17) recognition and reporting of maltreatment, abuse and neglect pursuant to chapter 260E;

(18) the center's risk reduction plan pursuant to section 142H.24;

(19) reduction of risk of sudden unexpected infant death pursuant to the requirements of subdivision 7 and section 142B.46; and

(20) transportation and field trip safety procedures pursuant to section 142H.33.

(c) Training for orientation may be used to meet in-service training requirements.

Subd. 2. **Child care basics training.** (a) Any program staff person hired after July 1, 2027, must complete child care licensing basics training no more than 90 days after the first date of direct contact with a child, unless the person has completed the training within the previous two years.

(b) Child care basics training covers information on effectively working in a child care center setting in Minnesota. Child care basics training must be developed and updated by the commissioner. Child care basics training may be used to meet in-service training requirements.

Subd. 3. **Child development and learning training.** (a) Program staff persons must complete at least two hours of child development and learning training within 90 days after the first date of direct contact with a child and every two calendar years thereafter. For the purposes of this subdivision, "child development and learning training" means any training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community.

(b) An individual is exempt from this subdivision if the individual:

(1) has taken a three-credit college course on early childhood development within the past five years;

(2) has received a bachelor's or master's degree in early childhood education or school-age child care within the past five years;

(3) is licensed in Minnesota as a prekindergarten teacher, an early childhood educator, a kindergarten to sixth grade teacher with a prekindergarten specialty, an early childhood special education teacher, or an elementary teacher with a kindergarten endorsement; or

(4) has received a Montessori certificate or diploma issued by American Montessori Society, Association Montessori International, or an institution accredited by the Montessori Accreditation Council for Teacher Education within the past five years.

Subd. 4. **Pediatric first aid.** (a) Before direct contact with a child, a program staff person must satisfactorily complete pediatric first aid. Pediatric first aid training completed within the previous two calendar years meets this requirement.

(b) Notwithstanding paragraph (a), a program staff person who has yet to complete initial pediatric first aid training may provide direct contact services within 90 days after the first date of direct contact with a child while under the continuous direct supervision of an individual who has met the pediatric first aid training requirements of this subdivision. For

purposes of this paragraph, "continuous direct supervision" means the program staff person is within sight or hearing of the program's supervising individual and the program's supervising individual is capable at all times of intervening to protect the health and safety of the children served by the program.

(c) The first aid training must have been provided by an individual approved to provide pediatric first aid instruction.

(d) A program staff person must complete training in pediatric first aid every two calendar years. Documentation of the training must be maintained at the center.

(e) Online training reviewed and approved by the commissioner satisfies the training requirement of this subdivision.

(f) Pediatric first aid training in this subdivision must not be used to meet in-service training requirements under subdivision 10.

Subd. 5. **Pediatric cardiopulmonary resuscitation.** (a) Before direct contact with a child, a program staff person must satisfactorily complete pediatric cardiopulmonary resuscitation (CPR) training, including CPR techniques for infants and children and the treatment of obstructed airways. Pediatric CPR training completed within the previous two calendar years meets this requirement.

(b) Notwithstanding paragraph (a), a program staff person who has yet to complete initial pediatric CPR training may provide direct contact services within 90 days after the first date of direct contact with a child, if they are under the continuous direct supervision of an individual who has met pediatric CPR training requirements under this subdivision. For the purposes of this paragraph, "continuous direct supervision" means the individual is within sight or hearing of the program's supervising individual to the extent that the program's supervising individual is capable at all times of intervening to protect the health and safety of the children served by the program.

(c) A program staff person must complete training in pediatric CPR every two calendar years. A center must maintain documentation of the trainings on site.

(d) A pediatric CPR training under this subdivision must incorporate a hands-on skill session to support the instruction and have been developed:

(1) by the American Heart Association or the American Red Cross; or

(2) using nationally recognized, evidence-based guidelines for pediatric CPR training.

(e) Pediatric CPR training must not be used to meet in-service training requirements under subdivision 10.

Subd. 6. **Sudden unexpected infant death training.** (a) Before direct contact with infants, program staff persons and volunteers must receive training on the standards under section 142B.46 and on reducing the risk of sudden unexpected infant death during orientation and each calendar year thereafter.

(b) Sudden unexpected infant death reduction training required under this subdivision must be at least one-half hour in length and include at minimum the infant sleep standards under section 142B.46, the risk factors related to sudden unexpected infant death, methods of reducing the risk of sudden unexpected infant death in child care, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death.

(c) Training taken under this subdivision may be used to meet the in-service training requirements under subdivision 10.

Subd. 7. **Abusive head trauma training.** (a) Before direct contact with children under school age, a program staff person must receive training on the risk of abusive head trauma during orientation and each calendar year thereafter.

(b) Abusive head trauma training under this subdivision must be at least one-half hour in length and include at minimum the risk factors related to shaking infants and young children, methods of reducing the risk of abusive head trauma in child care, and license holder communication with parents regarding reducing the risk of abusive head trauma.

(c) training taken under this subdivision may be used to meet the in-service training requirements under subdivision 10.

Subd. 8. **Child passenger restraint systems; training requirement.** (a) Before a license holder transports a child or children under age nine in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles.

(b) Training required under this subdivision must be repeated at least once every five years and include at minimum the proper use of child restraint systems based on the size, weight, and age of the child and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(c) Training required under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety.

(d) Training completed under this subdivision may be used to meet in-service training requirements under subdivision 10. Staff training completed within the previous five years is transferable upon change in employment to another child care center.

Subd. 9. **In-service training requirements.** (a) A license holder must ensure that program staff persons complete in-service training.

(b) In-service training completed within the past 12 months by a program staff person that is not specific to a child care center is transferable upon the program staff person's change in employment to another child care program. The program staff person must provide documentation of the completed training to the new child care program.

(c) All program staff persons, except substitutes and unsupervised volunteers, who work more than 20 hours per week must complete at least 20 hours of in-service training each calendar year.

(d) All program staff persons, except substitutes and unsupervised volunteers, who work 20 hours or less per week must complete at least ten hours of in-service training each calendar year.

(e) Substitutes and unsupervised volunteers must complete a minimum of two hours of training each calendar year and the training must include the topics identified under subdivision 11.

(f) The number of in-service training hours may be prorated for center directors and program staff persons not employed for an entire year.

(g) Pediatric first aid and pediatric CPR training must not be used to meet in-service training requirements.

Subd. 10. **In-service content.** (a) Each calendar year, in-service training must include the following:

(1) abusive head trauma training of at least one-half hour duration for individuals working with a child under school age pursuant to subdivision 8;

(2) the center policies and procedures for maintaining health and safety, including:

(i) allergy prevention and response training pursuant to section 142H.15, subdivision 5;

(ii) emergency preparedness and procedures pursuant to section 142H.23, subdivision 1;

(iii) handling emergencies, accidents, incidents, and injuries pursuant to section 142H.23, subdivision 2; and

(iv) handling and disposal of bodily fluids pursuant to section 142H.29, subdivision 10;

(3) maltreatment, abuse, and neglect reporting pursuant to chapter 260E;

(4) reduction of risk of sudden unexpected infant death training of at least one-half hour duration for individuals working with infants pursuant to the requirements of subdivision 7 and section 142B.46;

(5) a risk reduction plan pursuant to section 142H.24;

(6) the center policies and procedures on behavior guidance pursuant to section 142H.13; and

(7) the center policies and procedures on supervision pursuant to section 142H.24.

(b) At least once every two calendar years, in-service training must include the following:

(1) child development and learning pursuant to subdivision 4;

(2) at least one hour on cultural awareness and inclusion;

(3) pediatric first aid that meets the requirements of subdivision 5;

(4) pediatric cardiopulmonary resuscitation training that meets the requirements of subdivision 5; and

(5) at least one hour on identifying and supporting children with special needs.

(c) At least once every five calendar years, training must include child passenger restraint systems pursuant to subdivision 9, if applicable.

(d) The remaining hours of the in-service training requirement must be met by completing training in the Minnesota knowledge and competency framework areas.

Subd. 11. **Documentation required.** (a) The license holder must document completed training for program staff persons in a manner prescribed by the commissioner.

(b) For pediatric first aid and CPR trainings, the license holder must maintain copies of training cards or certificates issued by the training organization.

Sec. 10. **[142H.10] STAFF RATIOS, GROUP SIZE, AND STAFF DISTRIBUTION.**

Subdivision 1. **Staff-to-child ratios and maximum group size.** (a) Except as provided in this subdivision and section 142H.12 regarding naps and rest, the minimally acceptable staff-to-child ratios and the maximum group size within each age category are:

Age Category	Staff-to-Child Ratio	Maximum Group Size
Infant	1:4	8

Toddler	1:7	14
Preschooler	1:10	20
School-age child	1:15	30

(b) Except for groups that include an infant, the staff-to-child ratio may be doubled for no more than two hours during nap time. During the nap time, there must be enough program staff persons in the facility to meet staff-to-child ratio and staff distribution requirements under paragraph (a) and subdivision 2 for the groups in case of an emergency. The program must return to following the staff-to-child ratios and staff distribution requirements under paragraph (a) and subdivision 2 when the number of awake children exceeds the number of children who could be supervised by one program staff person under subdivision 1.

(c) The maximum group size applies at all times except during meals, outdoor activities, field trips, naps and rest, and special activities at the center such as guest speakers and holiday programs.

Subd. 2. **Staff distribution.** (a) The license holder must ensure that the following requirements for staff distribution are met and a documented staff schedule is kept in the administrative record.

(b) Except as provided in paragraphs (d) and (e), staff distribution within each age category must be as follows:

(1) the first staff member needed to meet the required staff child ratio must be a teacher;

(2) the second staff member must have at least the qualifications of an aide;

(3) the third staff member must have at least the qualifications of an assistant teacher; and

(4) the fourth staff member must have at least the qualifications of an aide.

(c) Only a program staff person can be included in meeting the staff-to-child ratios in this section.

(d) An aide must not work alone with a child unless the aide is performing certain duties as specified in section 142H.08, subdivision 1, paragraph (b).

(e) An assistant teacher or an aide may be substituted for a teacher during arrival and departure times if the total arrival and departure time does not exceed 25 percent of the center's daily hours of operation. For an aide to be substituted for a teacher under this subdivision, the aide must:

(1) be 18 years of age or older;

(2) have been employed by the child care center for a minimum of 30 days; and

(3) have completed the training required under section 142H.09, including orientation and the training required within the first 90 days of the first date of direct contact with a child.

(f) A volunteer who is included in the staff-to-child ratio must meet the requirements for the assigned staff position in sections 142H.06 to 142H.08.

(g) The pattern in paragraph (e) must be repeated until the number of staff needed to meet the staff-to-child ratio for each age category has been achieved.

Subd. 3. **Age category grouping.** (a) Each center must specify arrival and departure times of the day in their program's policies. Children in different age categories may be grouped according to paragraphs (b) and (c).

(b) During arrival and departure times, children in different age categories may be grouped together if:

(1) the staff-to-child ratio, group size, and staff distribution applied are for the age category of the youngest child present; and

(2) the group is divided when the number of children present reaches the maximum group size of the youngest child present.

(c) Outside of arrival and departure times, children in different age categories may be mixed within a group if:

(1) infants are not grouped with children of other age categories;

(2) there is no more than a 36-month range in age among children in a group, unless all children in the group are school age; and

(3) the staff-to-child ratios, group size, and staff distribution applied are for the youngest child present.

Subd. 4. **Age designation.** (a) Except as provided in this subdivision, a child must be designated as a member of the age category that is consistent with the date of birth of the child.

(b) A child with special health care needs must be included in the group that best meets the child's developmental needs, best interest of the child, and in accordance with the individual child care program plan for the child.

(c) A child may be designated as an "infant" up to the age of 18 months if the parent, teacher, and director determine that such a designation is in the best interest of the child. The center must document the determination and designation in the file of the child.

(d) A child may be designated as a "toddler" up to the age of 35 months if the parent, teacher, and director determine that the designation is in the best interest of the child. The center must document the determination and designation in the file of the child.

(e) A child may be designated as a "preschooler" at the age of 31 months if the parent, teacher, and director determine that the designation is in the best interest of the child. The center must document the determination and designation in the file of the child.

(f) When a child is transitioning age groups pursuant to subdivision 5 and with the child's new class, the child must be designated as if the child has already aged into the class.

Subd. 5. **Transitioning children.** (a) Transitions to the next age group may occur up to two weeks prior to the child aging into the next age group. The transition must be planned in advance based on the child's readiness and in consultation with parents and program staff.

(b) A center must develop a written policy on transitioning children to the next age group.

Sec. 11. **[142H.11] CHILD CARE PROGRAM PLAN AND ACTIVITIES.**

Subdivision 1. **General requirements.** The child care program plan must:

(1) include a statement mandating that children are supervised at all times as defined in section 142H.01, subdivision 38, and pursuant to the requirements of section 142H.24, subdivision 1;

(2) specify the age categories and number of children to be served by the program;

(3) specify the days and hours of operation of the program;

(4) describe the general educational methods to be used by the program and the religious, political, or philosophical basis, if any;

(5) be developed and evaluated in writing each calendar year by a program staff person qualified as a teacher or director under sections 142H.05 and 142H.06. Documentation of the evaluation, the date of the evaluation, and the signature of the teacher or director completing the evaluation must be maintained in the center administrative records;

(6) specify planned activities designed to support and nurture the whole child in all areas of the development and learning of the child, including but not limited to the following:

intellectual, social, emotional, and physical development. The activities must be in a manner consistent with the cultural and ethnic backgrounds of a child, as feasible;

(7) specify that the intellectual, social, emotional, and physical development of each child be documented in the record of the child and conveyed to the parent during the conferences specified under section 142H.20, subdivision 2;

(8) include a daily schedule of planned indoor and outdoor activities for each age category served;

(9) specify activities that are quiet, active, teacher directed, and child initiated;

(10) specify a variety of activities that require the use of varied equipment and materials;

(11) include a schedule if equipment is rotated between groups of children;

(12) describe use of technology and screen time for each age category; and

(13) be available to a parent for review upon request.

Subd. 2. **Outdoor activities.** (a) Child care activities must promote the physical, intellectual, social, and emotional development of the child. To facilitate child development, programs must include daily outdoor activities when weather conditions allow, as defined in this subdivision.

(b) The applicant must develop a written outdoor weather and activity policy. The license holder must ensure that the policies and procedures are carried out. The policies and procedures must incorporate guidance from national, state, or local authorities in public health and at a minimum require the provider to consider the following conditions when determining if outdoor play poses a health and safety risk:

(1) heat in excess of 100 degrees Fahrenheit accounting for heat index, or pursuant to advice of the local authority;

(2) cold less than 15 degrees Fahrenheit accounting for wind chill, or pursuant to advice of the local authority;

(3) extreme weather, including but not limited to a lightning storm, blizzard, tornado, or flooding;

(4) an air quality emergency order by a local or state authority on air quality or public health; or

(5) a lockdown notification ordered by a public safety authority.

(c) The center's outdoor weather and activity policy must specify, if children are to go outside beyond the temperature range specified in paragraph (b), clauses (1) and (2), what procedures will be used to keep the children safe, including but not limited to ensuring children have appropriate clothing, providing frequent indoor breaks, or matching the intensity of the activity level to the weather conditions.

(d) For toddlers, preschool, and school-age children attending four or more hours per day, the license holder must provide at least one opportunity for outdoor activity per day pursuant to paragraph (b).

(e) For infants attending four or more hours per day, the license holder must provide at least one opportunity for outdoor activity per day as practicable, pursuant to paragraph (b) and the individual needs of the infants in care.

(f) Programs operating three or fewer hours per day are exempt from the daily outdoor activity requirement.

(g) If the weather is not suitable for outdoor activities, the program must provide indoor gross motor play activities that support physical development.

Sec. 12. **[142H.12] NAPS AND REST.**

Subdivision 1. **Naps and rest policy.** An applicant must develop and a license holder must implement a policy for naps and rest that is consistent with the developmental level of the children enrolled in the center. The policy must include but is not limited to the requirements in this section, as applicable.

Subd. 2. **Parent consultation.** The parent of each child must be informed at the time the child is enrolled of the center's policy on naps and rest and be offered the opportunity to provide information specific to their child.

Subd. 3. **General nap and rest requirements.** (a) The child care center must provide a quiet space for children to nap and rest.

(b) Nap and rest time must be in accordance with the developmental needs of the child.

(c) Nap and rest areas must be lighted to allow for visual supervision of all children at all times.

(d) Evacuation routes must not be blocked by resting or napping children. Each child must have a free and direct means of escape, and the staff must have a clear path to each resting child, including full access to at least one long side of a crib, cot, or mat.

(e) A crib that meets the safety requirements of section 142B.45 must be provided for each infant for whom the center is licensed to provide care.

(f) The license holder must follow the infant safe sleep requirements under section 142B.46.

(g) Cribs, cots, and mats must be placed directly on the floor and must not be stacked when in use.

Subd. 4. **Monitoring napping infants.** (a) An infant must be supervised as defined in section 142H.01, subdivision 38, and pursuant to section 142H.24, subdivision 1, paragraph (b).

(b) Staff must conduct in-person checks of the sleeping infant every 15 minutes.

(c) When a baby monitor or other mechanical equipment is used to hear or see infants during sleep, the monitoring equipment must be:

(1) able to pick up the sounds of all infants in the separate room;

(2) actively monitored by program staff at all times; and

(3) checked daily prior to use to ensure it is working correctly. If equipment is malfunctioning, a program staff person must put in place an alternate means of supervision until the equipment can be fixed.

Subd. 5. **Confinement limitation.** A child who has completed a nap or rested quietly for 30 minutes must not be required to remain on a cot, mat, or in a crib. Any child who does not fall asleep during a designated nap time must have the opportunity to engage in quiet activities.

Subd. 6. **Bedding and sleeping equipment.** Separate bedding must be provided and stored separately for each child in care.

Sec. 13. **[142H.13] BEHAVIOR GUIDANCE.**

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

(b) "Behavior guidance" means an ongoing process where a program staff person offers constructive, positive, and developmentally appropriate guidance to a child to help manage the child's behavior in a socially acceptable manner.

(c) "Persistent unacceptable behavior" means when a child:

(1) exhibits behaviors that present a serious safety risk for the child or others and the program is not able to reduce or eliminate the safety concern; or

(2) significantly disrupts the learning environment and requires an increased amount of staff guidance and time to address the child's behavior. Significantly disruptive behavior may include physical aggression, verbal threats, or repetitive behaviors that have been addressed through standard behavior guidance techniques without improvement.

(d) "Redirection" means a positive guidance technique where a program staff person intervenes and guides a child away from potential problems toward constructive activity or talks with a child to help the child calm down and self-regulate.

(e) "Separation" means a form of behavior guidance that involves interruption of unacceptable behavior by the removal of a child from a situation with the intention of allowing the child an opportunity to pause and gain self-control. During a separation a child is isolated from participating in activities with other children. Separation of children must be done pursuant to subdivision 7.

Subd. 2. **Behavior guidance policies and procedures.** The applicant must develop written behavior guidance policies and procedures approved by the commissioner. The license holder must ensure that the policies and procedures are carried out. The policies and procedures must include:

(1) methods of promoting positive behavior as specified under subdivision 3;

(2) prohibited actions as specified under subdivision 4;

(3) addressing persistent unacceptable behavior as specified under subdivision 6; and

(4) separation from the group as specified in subdivision 7.

Subd. 3. **Methods of promoting positive behavior.** A license holder must promote positive behavior by:

(1) ensuring that each child is provided with a positive model of acceptable behavior;

(2) tailoring methods of promoting positive behavior to the developmental level of the children the center is licensed to serve;

(3) ensuring redirection is used, as appropriate in addressing the behavior of a child, to guide a child away from potential problems and toward constructive activity or to talk with a child to help them calm down and self-regulate;

(4) teaching children how to use acceptable alternatives to problem behavior to reduce conflict;

(5) protecting the safety and well-being of children, employees, and volunteers; and

(6) providing immediate and directly related consequences for the unacceptable behavior of a child.

Subd. 4. **Prohibited actions.** A license holder must prohibit the following actions by or at the direction of employees or volunteers:

(1) subjecting a child to corporal or physical punishment, including but not limited to rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, spitting, hitting, or spanking;

(2) subjecting a child to name calling, ostracism, shaming, derogatory remarks about the child or the child's family, cultural or racial slurs, yelling, or profane language that threatens, humiliates, or frightens the child;

(3) forcing a child to maintain an uncomfortable position or to continuously repeat physical movements;

(4) utilizing group punishments for the behavior of an individual child;

(5) separation of a child from the group except as provided in subdivision 7;

(6) punishment for not resting, napping, or sleeping; toileting accidents; failing to eat all or part of meals or snacks; or failing to complete an activity;

(7) denial of food or drink or forcing food or drink upon a child;

(8) denial of light, warmth, clothing, or medical care as a punishment for unacceptable behavior;

(9) the use of physical restraint other than to physically hold a child when containment is necessary to protect the child or others from harm;

(10) the use of mechanical restraints, including tying a child up, or any device or equipment intended to restrict or prevent movement as a means of discipline or for reasons unrelated to the child's care, safety, or planned activity;

(11) the use of prone or contraindicated restraints as prohibited in section 245A.211;

(12) the use of any substance given to a child to subdue or restrict movement or behavior;

(13) discipline and punishment must not be delegated to another child; and

(14) punishing or shaming a child for the actions of a parent, including but not limited to failure to pay fees, failure to provide appropriate clothing, failure to provide materials for an activity, or any conflict between the license holder or staff and the parent.

Subd. 5. **Additional provisions.** (a) When providing services to a child with a developmental disability or related condition, the license holder must follow section 142B.63.

(b) A program that cares for a child with a developmental disability or related condition must comply with the individual child care program plan requirements under section 142H.15.

Subd. 6. **Persistent unacceptable behavior.** (a) A program staff person who observes persistent unacceptable behavior must document the behavior of the child and staff response to the behavior, including:

(1) information on where the child was, what activity the child was doing, and the employees or volunteers present when the incident occurred; and

(2) staff actions, including the positive guidance techniques that were tried.

(b) When persistent unacceptable behavior as defined in subdivision 1, paragraph (c), occurs, a behavior plan must be developed to address the behavior documented in paragraph (a) in consultation with the child's parent, the program staff, and other professionals involved in the care and treatment of the child, as appropriate. The behavior plan must include but is not limited to the following:

(1) a description of the specific behavior;

(2) the planned behavior management method to be used in response to the behavior pursuant to subdivision 3 or any other previously approved methods; and

(3) an area to document the effectiveness of the plan and progress of the child.

(c) The plan must be signed and dated by the child's parent, the director, and other professionals involved in the care and treatment of the child, as applicable, and kept in the child's record.

(d) The plan and the child's progress must be reviewed at least twice each calendar year, or more frequently as needed, and changes must be made based on the child's needs and the input of the child's parent, program staff, or other individuals involved in the provision of care and treatment of the child. Documentation of the review must be kept in the child's record. If the child's parent and the program staff agree that the behavior plan is no longer needed, the license holder must document the date the behavior plan is no longer in effect.

(e) The license holder must ensure that all staff who work directly with the child are trained on the behavior plan prior to working with the child or when a new behavior plan is developed. Documentation of staff training must be maintained on file.

(f) The license holder must ensure that all staff who work directly with the child are trained on the behavior plan prior to working with the child or when a new behavior plan is developed. Documentation of staff training must be maintained on file.

Subd. 7. **Separation time from the group.** No child may be separated from the group unless the license holder has tried less intrusive methods of guiding the child's behavior that have been ineffective and the behavior of the child threatens the well-being of the child or other children in the center. Separation from the group must meet the following requirements:

(1) the separation time must be limited to the amount of time necessary for the child to gain self-control and rejoin the group;

(2) the duration of separation of the child must be documented, including the beginning and end time of the separation;

(3) infants and toddlers must not be separated from the group as a means of behavior guidance. Positive behavior guidance techniques such as redirection may be used with toddlers; and

(4) the child must be supervised as defined under section 142H.01, subdivision 38, while separated.

Sec. 14. **[142H.14] FURNISHINGS, EQUIPMENT, MATERIALS AND SUPPLIES.**

Subdivision 1. **General requirements.** (a) Each center must have on the premises the quantity and type of equipment and materials necessary to implement the child care program plan under section 142H.11 and the indoor and outdoor equipment requirements in subdivisions 2 and 3.

(b) Equipment and furniture must be durable, in good repair, structurally sound, stable, and free of sharp edges, dangerous protrusions, points where extremities of a child could be pinched or crushed, and openings or angles that could trap part of a child.

(c) License holders and program staff must ensure equipment and furnishings are not hazardous objects as specified in section 142H.34, subdivision 17.

(d) Equipment must be appropriate to the age and size of children and used in accordance with the manufacturer's instructions.

Subd. 2. **Indoor play equipment.** The license holder must provide sufficient indoor play equipment and materials so that at any point in the day when children are indoors and using equipment every child can choose from at least three activities involving equipment

or materials. The quantity of indoor equipment provided must be based on the maximum licensed capacity of the classroom and must be accessible to children as specified in subdivision 5.

Subd. 3. **Outdoor play equipment.** The license holder must provide sufficient outdoor play equipment and materials so that when all children are outdoors every child can choose from at least one activity involving equipment or materials. The quantity of outdoor equipment and materials provided must be based on the maximum licensed capacity and must be accessible to children as specified in subdivision 5.

Subd. 4. **Interest areas.** The license holder must have equipment and materials in each of the following developmental and interest areas to support a child's learning and growth:

(1) creative arts and crafts;

(2) construction and building;

(3) social interaction, dramatic play, or practical life activities;

(4) math and science;

(5) music;

(6) fine motor skills;

(7) physical and movement activities;

(8) sensory exploration activities; and

(9) language and literacy.

Subd. 5. **Equipment rotation and accessibility.** A child care program may rotate equipment throughout the day as specified in the child care program plan if the number of choices required in subdivisions 2 and 3 is available for each child in attendance. Equipment and materials from each interest area must be accessible to children at least once per day.

Subd. 6. **Furnishings.** The license holder must ensure that each child has access to furniture that is developmentally appropriate and the appropriate size, including at a minimum:

(1) one diaper changing table for every 12 infants or 14 toddlers. The same table may not be counted to fulfill the requirement under this clause for both infants and toddlers;

(2) one hands-free covered diaper container per diaper changing table;

(3) one crib and waterproof mattress per infant, including enough cribs with wheels to evacuate the number of infants the program is licensed to serve;

(4) one cot or mat per toddler or preschooler. This clause does not apply to programs operating for less than five hours per day if rest is not indicated as part of the center's child care program;

(5) for infants, one nonfolding seating option per child based on licensed capacity; and

(6) for toddlers, preschoolers, and school-age children, one nonfolding seating option per child based on licensed capacity, with a corresponding amount of table space to allow the child to do table work or eat a meal while seated.

Subd. 7. **Supplies.** (a) The license holder must maintain enough diapers, disposable paper for the diaper changing table, facial tissues, liquid hand soap, and single-service towels to maintain cleanliness and sanitation for children in care.

(b) The license holder must provide at least two sets of sheets for each crib.

Sec. 15. **[142H.15] CHILDREN WITH SPECIAL HEALTH CARE NEEDS OR DISABILITIES.**

Subdivision 1. **Child with special health care needs or disabilities.** For the purposes of this section, "child with special health care needs or disabilities" means a child who:

(1) has developmental disabilities or is otherwise eligible for case management pursuant to Minnesota Rules, parts 9525.0004 to 9525.0036;

(2) has been identified by the local school district as a child with a disability as defined in section 125A.02, subdivision 1; or

(3) has been determined by a health care provider as defined in section 142H.01, subdivision 22; licensed psychiatrist; licensed psychologist; or licensed consulting psychologist as having a special health care need or disability relating to physical, social, or emotional development.

Subd. 2. **Report to parent.** The license holder must inform the parent when there is a developmental concern or potential special health care need of a child that was not previously identified.

Subd. 3. **Individual child care program plan.** (a) When a license holder admits a child with a disability or special health care need or a special need is identified, the license holder must ensure that an individual child care program plan (ICCPP) is developed in a form and manner prescribed by the commissioner to meet the child's individual needs.

(b) When developing or updating the ICCPP, the license holder must obtain relevant information from the child's parent and program staff who work directly with the child.

(c) For a child who meets the criteria in subdivision 1, clause (1), the ICCPP must be coordinated with the child's individual service plan (ISP).

(d) For a child who meets the criteria in subdivision 1, clause (2), the ICCPP must be coordinated with the child's individualized educational plan (IEP).

(e) For a child who meets the criteria in subdivision 1, clause (3), the ICCPP must be coordinated with the child's health care provider or other necessary medical professionals.

(f) The license holder must ensure that all program staff who work directly with the child are trained on the ICCPP prior to working with the child. Documentation of staff training must be maintained on file.

(g) Before the ICCPP is implemented, the parent and the director must sign and date the form. The ICCPP must be kept in the child's record.

(h) The ICCPP must be reviewed and updated at least once each calendar year and more frequently if needed. The ICCPP must be signed and dated by the parent and the director upon their yearly review.

(i) The most recent ICCPP must be available at all times to program staff when the child is in care.

Subd. 4. **Inclusion.** All activities must be designed to include all children unless a specific medical contraindication exists or an exclusion is otherwise specified in a child's ICCPP.

Subd. 5. **Allergy prevention and response.** (a) An applicant must develop a written policy on allergy prevention and response. A license holder must ensure the policy is carried out and provided to parents at the time of enrollment.

(b) Before admitting a child for care, the license holder must obtain documentation of any known allergy from the child's parent or the child's health care provider.

(c) If a child has a known allergy, the license holder must maintain current information about the allergy in the child's record and develop an ICCPP pursuant to subdivision 3, including:

(1) a description of the allergy;

(2) specific triggers and avoidance techniques;

(3) symptoms of an allergic reaction;

(4) procedures for responding to an allergic reaction, including medication to be administered in an emergency situation and dosages; and

(5) the child's health care provider contact information.

(d) If a child has an ICCPP related to a food allergy, the ICCPP must be readily available to the person in the area where food is prepared and served to the child. If food is prepared off site, the center must notify the person or entity preparing the food of any food allergies of children in their care. Food allergy information for all children in care must be readily available to staff in the classroom and wherever food is served.

(e) The license holder must contact the parent of the child immediately after any instance of exposure or allergic reaction.

(f) The license holder must call 911 when epinephrine is administered to a child in care.

Subd. 6. **Temporary physical needs.** If a child has a temporary physical need as identified by their health care provider, including but not limited to a brace, cast, or helmet, the license holder must maintain current documentation about the temporary physical need from the child's health care provider and any necessary accommodations in the child's record. The license holder must ensure staff who work with the child are aware of the child's temporary physical need and follow the identified necessary accommodations. An ICCPP is not required for documenting a temporary physical need under this subdivision and the accommodation.

Sec. 16. **[142H.16] NIGHT CARE PROGRAM.**

Subdivision 1. **Applicability.** A license holder providing overnight care must comply with this section.

Subd. 2. **Furnishings.** Each child enrolled in a night care program must be provided with a crib or bed, described as follows:

(1) a crib that meets the requirements under section 142B.45 and two sets of sheets must be provided for each infant and meet the requirements under section 142H.14;

(2) an individual age-appropriate bed with two sets of sheets and a blanket or quilt must be provided for each toddler, preschooler, or school-age child;

(3) each bed or crib must have a waterproof mattress or mattress pad that can be cleaned and disinfected;

(4) bedding and sleeping equipment must be cleaned and disinfected as specified in section 142H.31, subdivision 4, clause (3); and

(5) separate bedding must be provided and stored separately for each child in care.

Subd. 3. **Clothing intended for sleeping.** The license holder must ensure that all children are put to bed in clothing for sleeping as designated by the parent of the child.

Subd. 4. **Personal care items.** The license holder must ensure that all children have personal items needed to clean up and prepare for sleep. The items must include an individual washcloth, towel, toothbrush, toothpaste, and liquid hand soap.

Subd. 5. **Meals and snacks.** (a) The license holder must ensure that a child who will be present in the center has had or will be provided with an evening meal. A bedtime snack must be available for all children in attendance. Eating times and schedules for the individual child must be consistent with patterns established in consultation with the parent of the child.

(b) Night care programs are exempt from the requirements of section 142H.32, subdivision 7.

Subd. 6. **Staffing.** At least two program staff persons, one of whom must qualify as a teacher under section 142H.06, must be present in the center at all times during the hours the night program is in operation. When more than 80 percent of the children present are asleep, the remaining program staff persons needed to meet the required staff-to-child ratio must have at least the qualifications of an aide. Program staff must be awake, dressed, and provide supervision as specified in sections 142H.01, subdivision 38, and 142H.12 to children who are sleeping.

Subd. 7. **Hygiene assistance.** The license holder must ensure that children have the opportunity to wash up and brush their teeth before bedtime. Program staff must assist children during washing and changing clothes according to the developmental needs of the child.

Subd. 8. **Showers and bathtubs.** The license holder must ensure bathtubs and showers are equipped to prevent slipping, if the center provides bathing.

Subd. 9. **Bathing procedures.** The center must have written permission from the parent prior to allowing the child to bathe and ensure bathtubs and showers are cleaned and disinfected after each use. The tub or showers do not have to be disinfected between uses if the children are siblings and the parent has provided written consent. All children must bathe separately unless the children are siblings and the parent has provided written consent that the children can be bathed together.

Subd. 10. **Privacy.** To ensure privacy, school-age boys and girls must be separated during bedtime washing and changing activities.

Subd. 11. **Sleeping arrangements.** The center must provide sleeping arrangements so that sleeping children are cared for separately from children who are awake and so that sleeping children are not disturbed by arrivals and departures. Infants must have a sleep area separate from the center's play and activity areas.

Subd. 12. **Bedtime.** A child's bedtime must be scheduled in consultation with the child's parent.

Subd. 13. **Light.** The center must provide adequate lighting indoors in all areas, including bathrooms, hallways, and sleeping rooms to ensure that staff are able to see all children at all times.

Subd. 14. **Outdoor illumination.** The center must ensure that parking areas, outdoor walkways, and all building entrances are adequately lighted for safety and security.

Subd. 15. **Program emphasis.** A license holder operating a night care program must comply with the child care program standards in 142H.11.

Subd. 16. **Exceptions.** The outdoor activity area required by section 142H.34, subdivision 7; outdoor activities required by section 142H.11, subdivision 2; and outdoor equipment required by section 142H.14 need not be provided for children enrolled in a night care program.

Sec. 17. **[142H.17] DROP-IN CHILD CARE PROGRAMS.**

Subdivision 1. **Drop-in child care programs.** If a license holder chooses to operate as a drop-in child care program, the license holder must comply with the requirements in this section.

Subd. 2. **Exemptions.** (a) Drop-in child care programs that meet one of the requirements in paragraph (b) are exempt from:

(1) section 142H.10;

(2) section 142H.11, subdivision 1, clauses (6) and (7); and

(3) section 142H.12, subdivisions 3 and 5, except for infants and toddlers.

(b) A drop-in child care program is exempt from the requirements in paragraph (a) if the program operates:

(1) in a child care center that houses no child care program except the drop-in child care program;

(2) in the same child care center but not during the same hours as a regularly scheduled ongoing child care program with a stable enrollment; or

(3) in a child care center at the same time as a regularly scheduled ongoing child care program with a stable enrollment, but activities, except for bathroom use and outdoor play, are conducted separately from each other.

Subd. 3. **Staffing requirements.** (a) A drop-in child care program must have at least two program staff persons on site whenever the program is operating: the director or a designee and a program staff member who is qualified as a teacher.

(b) If the drop-in child care program has additional staff who are on call as a mandatory condition of their employment, the minimum child-to-staff ratio may be exceeded only for preschool and school-age children by a maximum of four children for no more than 20 minutes while additional staff are in transit. If the ratio is exceeded for more than 20 minutes, the license holder must review the mandatory on-call staff procedures and revise as necessary to ensure compliance with this section, including hiring additional on-call staff as needed.

(c) Whenever there is a total of 20 children or more at a drop-in child care center, children that are younger than 30 months must be cared for in a separate group. The group may contain children up to 60 months old. The group must be cared for in an area that is physically separated from older children.

(d) In drop-in care programs that serve both infants and older children, children up to 30 months old may be supervised by assistant teachers as long as other staff are present in appropriate ratios.

(e) A drop-in child care program may care for siblings who are all at least 16 months old together in any group. For purposes of this section, "sibling" is defined as sister or brother, half sister or half brother, or stepsister or stepbrother.

Subd. 4. **Staff-to-child ratio requirements in a drop-in program.** The minimum staff-to-child ratio that a license holder may maintain in a drop-in program is:

(1) for infants, one program staff person for every four infants;

(2) for toddlers, one program staff person for every seven children;

(3) for preschoolers, one program staff person for every ten children; and

(4) for school-age children, one program staff person for every 15 children.

Subd. 5. **Staff distribution.** (a) The minimum staff distribution pattern for a drop-in child care program is:

(1) the first staff member needed to meet the required staff-to-child ratio must be a teacher;

(2) the second and third staff members must have at least the qualifications of a child care aide; and

(3) the fourth staff member must have at least the qualifications of an assistant teacher.

(b) The pattern in paragraph (a) must be repeated until the number of staff needed to meet the staff-to-child ratio for each age category has been achieved.

Sec. 18. **[142H.18] EXCLUSION OF SICK CHILDREN .**

Subdivision 1. **Care of sick children.** If a child becomes sick while at the center, the child must be isolated from other children in care and the child's parent called immediately. When determining if a child is sick and exclusion is necessary, license holders must follow:

(1) the requirements on reportable diseases in Minnesota Rules, parts 4605.7040, 4605.7070, and 4605.7080; and

(2) guidelines from the commissioner of health on infectious diseases in child care settings.

Subd. 2. **Notification.** (a) A child care center's program policies must require a parent to inform the center within 24 hours, exclusive of weekends and holidays, when a child is diagnosed by a child's health care provider or dental care provider as having a reportable or infectious disease as specified in subdivision 1.

(b) The license holder must ensure that the commissioner of health is notified of any suspected case of reportable disease as specified in Minnesota Rules, parts 4605.7040, 4605.7050, or 4605.7080, within 24 hours of receiving the parent's or staff report. Documentation of the notification must be kept at the center.

(c) The license holder must notify the parents of exposed children within 24 hours of when a parent, employee, or volunteer notifies the center of a reportable disease under subdivision 1, lice, scabies, impetigo, ringworm, or chicken pox. The notice must be posted in a clearly visible, accessible place or provided individually to each parent of a child who was exposed.

Subd. 3. **Return to center.** Children with a reportable or infectious disease as specified in subdivision 1 must be excluded from the center for a length of time as specified in the commissioner of health guidelines on infectious diseases in child care settings and until the child can participate in routine activities without more staff supervision than usual. The

center must exclude a child for a longer period if the child's health care provider determines that it is necessary.

Sec. 19. **[142H.19] SICK CARE PROGRAM.**

Subdivision 1. **Licensure of sick care programs.** If a license holder chooses to operate as a sick care program, the license holder must operate a sick care program that complies with the requirements in this section.

Subd. 2. **Review of admission and health policies and practices.** (a) A licensed physician, physician assistant, or advanced practice registered nurse with a specialization in pediatric care must review and approve a sick care program's admission policy at the time of initial license application, after the first six months of initial operation, and at least once each calendar year.

(b) The review must include consultation with the licensed registered nurse or physician responsible for admissions.

(c) A report of the findings must be sent to the commissioner with the initial application for licensure, and subsequent reports must be placed in the center's administrative record.

Subd. 3. **Evaluation of a sick child.** (a) A license holder that operates a sick care program must evaluate the condition of a sick child before admitting the child to the center.

(b) The evaluation must be based on the physical symptoms of the child each day of admission, the probable contagion and risk to the health of others present, the ability of the program to provide the care the child requires, and whether the child can be grouped together with other children in care with contagious or noncontagious illnesses. Documentation of the evaluation must be placed in the child's record.

(c) Before admitting a child to a sick care program:

(1) a parent must describe the child's symptoms over the phone;

(2) a health care provider affiliated with the center must tell the parent whether the parent may bring the child to the center for further evaluation; and

(3) the health care provider must conduct a physical assessment of the child and obtain a health history from the parent at the center.

Subd. 4. **Information to parents.** A summary of the sick care program's health care policies and practices and the center's procedures for notification of parents in the event of an emergency must be given to the parent the first time a child is admitted and every admission following a change to any of the information.

Subd. 5. **Parent conference exception.** Centers licensed to provide child care exclusively to sick children are not required to provide parent conferences under section 142H.20, subdivision 2.

Subd. 6. **Child care program emphasis exception.** A sick care program does not need to meet the child care program plan requirements under section 142H.11. However, the child care program plan for the care of sick children must emphasize quiet activities.

Subd. 7. **Group size and age category grouping exceptions.** The maximum group sizes specified under section 142H.10, subdivision 1, and the age category grouping restrictions under section 142H.10, subdivision 3, do not apply to sick care programs. There must be no more than 16 children in sick care in the same room at the same time.

Subd. 8. **Staff-to-child ratios and staff distribution requirements.** (a) A one-to-four staff-to-child ratio must be maintained at all times in a room used to care for sick children.

(b) At least two program staff persons must be present in a center operating a sick care program whenever sick children are in care.

(c) The first program staff person must be a registered nurse. The remaining program staff persons must at least meet the qualifications and follow the staff distribution pattern under section 142H.10.

Subd. 9. **Limitation on staff assignment.** Staff must not care for nonsick children or prepare food for nonsick children on the same day as sick children. Staff caring for sick children must not enter the kitchen used to prepare food for nonsick children.

Subd. 10. **Food preparation.** Food provided by the license holder and prepared at the center must be prepared in a room separate from rooms where sick care is provided and must be delivered to each sick care room in individual servings and in covered containers. Procedures for preparing, handling, and serving food and washing food, utensils, and equipment must comply with the requirements in the Minnesota Food Code, Minnesota Rules, chapter 4626.

Subd. 11. **Menus.** Menus for sick children must be modified to meet the individual needs of the child.

Subd. 12. **Additional facility requirements.** A license holder operating a sick care program must provide:

(1) a room or rooms that are exclusively used to care for sick children and that are not used at any time for any other child care purpose; and

(2) toilets and hand sinks that are within or immediately adjacent to the room or rooms used for sick care and are not used by well children in care.

Subd. 13. **Outdoor activity area, activities, and equipment exception.** Sick care programs under this section are exempt from the requirements for an outdoor activity area under section 142H.34, subdivision 7; outdoor activities under section 142H.11, subdivision 2; and outdoor equipment under section 142H.14.

Subd. 14. **Cleaning and disinfection.** Floors in rooms where sick care is provided and all linens, toileting equipment, sinks, furnishings, objects, and equipment used by sick children must be cleaned and disinfected at least daily and as needed pursuant to the requirements under section 142H.31.

Subd. 15. **Bedding and sleeping equipment.** (a) Each sick child must be provided appropriate bedding and sleeping equipment, depending on the age of the child, as follows:

(1) a crib and crib sheets pursuant to the requirements of section 142B.45, cot, mat, or bed, depending on the age of the child;

(2) a pillow, except if the child is an infant;

(3) a pillowcase, except if the child is an infant; and

(4) a blanket or quilt, except if the child is an infant.

(b) Bedding provided by the center must be laundered after each use. Sleeping equipment must be cleaned and disinfected after each use.

Sec. 20. **[142H.20] INFORMATION TO PARENTS.**

Subdivision 1. **Policies provided to parents.** At the time of a child's enrollment, the center must provide the parent with written notification of the:

(1) ages and numbers of children the center is licensed to serve;

(2) hours and days of operation;

(3) child care program options the center is licensed to operate, including a description of the program's educational methods; the program's religious, political, or philosophical basis, if any; and how parents may review the center's child care program plan;

(4) policy on parent conferences and notification to a parent of a child's intellectual, physical, social, and emotional development;

(5) policy requiring a health care summary and immunization record of a child;

(6) policies and procedures for the care of children who become sick at the center and parent notification practices for the onset of or exposure to a contagious illness or condition pursuant to section 142H.18 or when there is an emergency or injury requiring medical attention;

(7) policies and procedures for administering first aid and sources of care to be used in case of emergencies;

(8) policies on the administration of medicine;

(9) procedures for obtaining written parental permission for transportation of children and field trips as required in section 142H.33, subdivision 4, paragraph (d);

(10) procedures for obtaining written parental consent for research, cameras, and social media participation pursuant to section 142H.22;

(11) policies on transitioning a child to the next age group, pursuant to section 142H.10;

(12) policies on the provision of meals and snacks;

(13) behavior guidance policies and procedures;

(14) presence of pets;

(15) policy on visitation and parental access to children pursuant to section 142H.21;

(16) policy on the prohibition of smoking, use of tobacco products, vaping, electronic cigarettes, alcohol, and drugs on the premises of the program pursuant to section 142H.29, subdivision 11;

(17) policy on use of technology and screen time pursuant to section 142H.11, subdivision 1, clause (12);

(18) telephone number of the Department of Children, Youth, and Families, Division of Licensing;

(19) policy on naps and rest pursuant to section 142H.12; and

(20) procedures for notifying parents of an evacuation, including procedures for reunification with families.

Subd. 2. **Parent conferences.** The license holder must inform the parent of a child's progress and:

(1) complete individual assessments of each child's intellectual, physical, social, and emotional development at least twice a year. Individual assessments for school-age children must be completed at least once a year;

(2) plan and offer parent conferences by program staff at least twice a year to review and discuss the child's assessment. Parent conferences for school-age children must be planned and offered at least once a year; and

(3) maintain documentation of the child's assessment and that individual parent conferences were planned and offered in each child's record.

Subd. 3. **Daily reports for infants and toddlers.** Daily written individualized reports must be provided to the parent of an infant or toddler about the child's food intake, elimination, sleeping patterns, and general behavior.

Sec. 21. **[142H.21] PARENT VISITATION AND ACCESS TO PROGRAM.**

(a) The center must have a parent visitation and access policy that meets the requirements of this section at a minimum.

(b) An enrolled child's parent must be allowed access to their child at any time while the child is in care unless a legal restriction or court order restricts access.

(c) A copy of the order or other legal restriction in paragraph (b) must be kept in the child's record.

Sec. 22. **[142H.22] CONSENT FOR RESEARCH, CAMERAS, AND SOCIAL MEDIA PARTICIPATION.**

Subdivision 1. **Policy.** A center must have and follow a policy governing the center's use of social media and the use of photos and videos of children in care. The policy must include:

(1) procedures for obtaining written consent from parents for release of photos and videos of children for promotional or publicity purposes; and

(2) a statement prohibiting any employee or volunteer from posting content of children in care or enrolled families on a personal social media account or public digital platform, including photos, videos, or personal identifying information of the children.

Subd. 2. **Participation in research, fundraising, or public relations projects.** (a) The license holder must obtain written permission from a parent before a child is involved in research, fundraising, or public relations projects while at the center. A separate written permission form must be obtained before each occasion of a research, fundraising, or public relations activity.

(b) The permission form must be maintained in the child's record.

Sec. 23. **[142H.23] EMERGENCY AND ACCIDENT POLICIES AND RECORDS.**

Subdivision 1. **Emergency preparedness plan.** (a) An applicant must develop a written plan for emergencies that require evacuation, relocation, sheltering in place, or lockdown resulting from a fire, blizzard, tornado or other natural disaster, or other threatening situations that may pose a health or safety hazard to a child, such as an intruder or violence at the facility. A license holder must carry out the emergency plan during emergencies. The plan must be written on a form developed by the commissioner and include:

(1) procedures for an evacuation, including building evacuation routes and identification of primary and secondary exits;

(2) procedures for relocation, including a designated relocation site;

(3) procedures for sheltering in place and lockdown;

(4) procedures for notifying a child's parent of an evacuation, relocation, sheltering in place, or lockdown, including procedures for reunification with families;

(5) accommodations for a child with a disability or a chronic medical condition;

(6) accommodations for infants and toddlers;

(7) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(8) procedures for continuing operations in the period during and after a crisis; and

(9) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities.

(b) A license holder must review and update the emergency plan at least once each calendar year and as needed when changes to the circumstances or facilities necessitate an updated plan. Documentation of the yearly review and when changes are made must be maintained in the program's administrative records.

(c) Program staff must be trained on the emergency plan at orientation as specified under section 142H.09 when changes are made to the plan and at least once each calendar year. Training must be documented and maintained on site.

(d) A center must have an operable on-site flashlight for use in an emergency situation. A cell phone may not be used to meet this requirement.

(e) A license holder must conduct fire drills every month and hold tornado drills monthly from April 1 through September 30. Fire and tornado drills must be documented and include

the date of the drill, the start and end time of the drill, and the name of the program staff person completing the documentation. Documentation must be maintained in the program's administrative records.

(f) Primary and secondary exits and evacuation routes must remain unblocked.

Subd. 2. **Emergencies, accidents, incidents, and injuries.** (a) The policies and procedures for emergencies, accidents, incidents, and injuries must include:

(1) procedures for administering first aid;

(2) procedures for the daily inspection of potential hazards;

(3) procedures for fire prevention and procedures to follow in the event of a fire, persons responsible for the evacuation of children and areas for which they are responsible, instruction on how to use a fire extinguisher, and instructions on how to close off the fire area;

(4) procedures to follow when a child is missing, including when a school-age child does not arrive at the center when expected after school;

(5) procedures to follow if a person who is unknown, unauthorized, incapacitated, or suspected of abuse attempts to pick up a child or if no one comes to pick up a child. The procedure must include a practice for verifying a person's identity;

(6) procedures for obtaining emergency medical care; and

(7) procedures for recording emergencies, accidents, incidents, and injuries involving a child enrolled in the center. The written record must include:

(i) the name and age of the child involved;

(ii) the name of employees or volunteers present;

(iii) the date, time, and place of the emergency, accident, incident, or injury;

(iv) the type of injury;

(v) actions taken by staff; and

(vi) to whom the emergency, accident, incident, or injury was reported.

(b) At a minimum, the emergency, accident, incident, or injury must be reported in writing to the parent and as otherwise required in section 142H.28.

(c) Each calendar year, the license holder must conduct an analysis of the emergencies, accidents, incidents, and injuries that have been documented pursuant to paragraph (a),

clause (7). Documentation of the yearly analysis and any modification of the center's policies based on the analysis must be maintained in the program's administrative records.

(d) The license holder must post a facility floor plan in a visible location in each classroom and other areas in the facility where child care is provided. The posted floor plan in each area must include:

(1) identification of primary and secondary exits;

(2) building evacuation routes;

(3) identification of tornado shelter and other shelter-in-place locations;

(4) identification of staff positions responsible for the evacuation or sheltering of children;

(5) the name and address of the designated relocation site; and

(6) phone numbers and sources of emergency medical services, the poison control center, the fire department, and the department's licensing division.

(e) The license holder must ensure program staff are trained on the emergency, accident, incident, and injury policies and procedures at orientation as required in section 142H.09 when changes are made to the policies and procedures and at least once each calendar year. Training must be documented and maintained on site.

Sec. 24. **[142H.24] SUPERVISION AND RISK REDUCTION.**

Subdivision 1. **Supervision; sight and hearing exceptions.** (a) A child is still supervised as defined in section 142H.01, subdivision 38, when:

(1) an infant is placed in a crib to sleep and a program staff person is within sight or hearing of the infant pursuant to section 142H.12, subdivision 4;

(2) a single school-age child uses a restroom that is not available to the public when the child care center is operating and serving children and a program staff person has knowledge of the child's activity and location and checks on the child at least every five minutes. When services are provided away from the child care facility, including but not limited to field trips, a school-age child who uses a restroom that is available to the public must be accompanied by a program staff person;

(3) a school-age child leaves the classroom but remains within the licensed child care center space to deliver or retrieve items from the child's personal storage space and a program staff person has knowledge of the child's activity and location and checks on the child at least every five minutes; or

(4) a single preschool child uses an individual, private restroom within the classroom with the door closed and a program staff person has knowledge of the child's activity and location, can hear the child, and checks on the child at least every five minutes. A shared restroom between two separate rooms that has a door into each room is not considered an individual, private restroom for the purposes of this clause.

(b) A program must account for each exception in paragraph (a) in the risk reduction plan under subdivision 2.

Subd. 2. **Risk reduction plan.** (a) The license holder must develop a risk reduction plan that identifies the general risks to children served by the child care center in a form and manner prescribed by the commissioner.

(b) The license holder must establish procedures to minimize identified risks, train staff on the procedures, and review the procedures each calendar year.

(c) The risk reduction plan must include an assessment of risk to children the center serves or intends to serve and identify specific risks based on the outcome of the assessment. The assessment of risk must be composed of:

(1) an assessment of the risks presented by the facility where the licensed services are provided, including an evaluation of:

(i) the condition and design of the facility and its outdoor space, bathrooms, and storage areas;

(ii) the accessibility of medications and cleaning products that are harmful to children; and

(iii) the existence of areas that are difficult to supervise; and

(2) an assessment of the risks presented by the environment for each facility and for each site, including an evaluation of the type of grounds and terrain surrounding the building and the proximity to hazards, busy roads, and publicly accessed businesses.

(d) The risk reduction plan must include a statement of measures that will be taken to minimize the risk of harm presented to children for each risk identified in the assessment under paragraph (c) related to the facility and environment.

(e) In addition to any program-specific risks identified in paragraph (c), the plan must include specific policies and procedures that minimize the risk of harm or injury to children, including from:

(1) closing children's fingers in doors, including cabinet doors;

(2) leaving children in the community without supervision;

(3) children leaving the facility without supervision;

(4) dislocation of children's elbows by program staff pulling or lifting children by the hands or wrists or swinging by the arms;

(5) burns, including from hot food or beverages, whether served to children or being consumed by program staff, and devices used to warm food and beverages;

(6) injuries from equipment, such as scissors and glue guns;

(7) sunburn;

(8) feeding children foods to which they are allergic;

(9) children falling from changing tables;

(10) children accessing dangerous items or chemicals or coming into contact with residue from harmful cleaning products;

(11) traffic and pedestrian accidents, including when walking with children on neighborhood walks, to an off-site outdoor play area, or in areas with heavy traffic or difficult terrain such as railroad tracks; and

(12) children choking or suffocating.

(f) The plan must ensure hazardous objects as defined in section 142H.34, subdivision 17, are inaccessible to children.

(g) The plan must include specific policies and procedures to ensure adequate supervision of children at all times as defined in subdivision 1 and section 142H.01, subdivision 38, and pursuant to the staffing requirements of section 142H.10, subdivision 1, with particular emphasis on:

(1) times when children are transitioned from one area within the facility to another, including the use of a name-to-face check during transition time;

(2) nap-time supervision, including infant sleep supervision;

(3) child arrival and departure times, including when children arrive or depart from the center by bus;

(4) supervision during outdoor play, outdoor learning activities, and community activities, including but not limited to field trips and neighborhood walks;

(5) supervision of children in hallways;

(6) supervision of preschool children when using an individual private restroom within the classroom; and

(7) supervision of school-age children when using the restroom and visiting the child's personal storage space.

Subd. 3. **Yearly review of risk reduction plan.** (a) The license holder must review the risk reduction plan each calendar year and document the review.

(b) When conducting the review, the license holder must consider incidents that have occurred in the center since the last review, including:

(1) incidents covered by the assessment factors in subdivision 2;

(2) the internal reviews conducted under section 142H.36, if any;

(3) substantiated maltreatment findings, if any; and

(4) any other incidents that caused injury or harm to a child.

(c) Within ten days following any change to the risk reduction plan, the license holder must train program staff on the change and document that the staff were trained on the change.

Sec. 25. **[142H.25] CENTER ADMINISTRATIVE RECORDS.**

(a) In addition to the personnel records requirements under section 142B.03, subdivision 1, paragraph (a), a center must maintain the following records:

(1) a record of the information given to parents specified in section 142H.20;

(2) the personnel records specified in section 142H.26;

(3) the children's records specified in section 142H.27;

(4) health consultant reviews of the center's health policies and practices as specified in section 142H.29, subdivision 2;

(5) the child care program plan specified in section 142H.11;

(6) the emergencies, accidents, incidents, and injuries records specified in section 142H.23, subdivision 2;

(7) the child separation reports mandated in section 142H.13;

(8) daily center and classroom attendance records specified in section 142H.30; and

(9) staffing schedules.

(b) The requirements in section 142B.03, subdivisions 1 and 2, apply to records retained pursuant to this section.

Sec. 26. **[142H.26] PERSONNEL RECORDS.**

A license holder must maintain a current personnel record for each program staff person in a manner prescribed by the commissioner and consistent with section 142B.03. The personnel record for each program staff person must contain:

(1) the program staff person's name, home address, telephone number, date of birth, and emergency contact information;

(2) the program staff person's first date of direct contact and first date of unsupervised direct contact with a child;

(3) documentation indicating that the program staff person meets the requirements of the staff person's job in sections 142H.05 to 142H.08; and

(4) the program staff person's hire date and last day of employment, as applicable.

Sec. 27. **[142H.27] CHILDREN'S RECORDS.**

Subdivision 1. **Requirements.** Prior to or on the day of enrollment in the center, the license holder must maintain a record on site for each child served by the program. The record must contain:

(1) the child's full name, date of birth, and current home address;

(2) the child's date of enrollment in the program;

(3) the name, address, and telephone number of the child's parent;

(4) the name and telephone number of at least one emergency contact person who can be contacted if a parent cannot be reached in an emergency or when there is an injury requiring medical attention;

(5) the names and telephone numbers of any additional persons authorized by the parent to pick up the child from the center;

(6) the child's health and immunization information required by section 142H.29, subdivisions 3 and 4;

(7) written authorization for the license holder to act in an emergency or when a parent or designee cannot be reached or is delayed;

(8) the hours and days of the week the child will attend the center;

(9) for infants and toddlers, a description of the child's eating, sleeping, toileting, and communication habits and effective methods for comforting the child;

(10) documentation of any dietary or medical needs of the child;

(11) documentation of a child's individual child care program plan as required by section 142H.15; and

(12) the date of parent conferences and a summary of the information provided to the parent at the conferences.

Subd. 2. **Disclosure.** The license holder must not disclose a child's record to any person other than the child, the child's parent, the child's legal representative, employees of the license holder, or the commissioner unless the child's parent has given written consent. This subdivision does not apply to information needed by a first responder in the case of an emergency.

Sec. 28. **[142H.28] REPORTING REQUIREMENTS.**

Subdivision 1. **Maltreatment, abuse, and neglect reporting.** The license holder must comply with the reporting requirements for abuse and neglect specified in chapter 260E.

Subd. 2. **Other reporting.** Within 24 hours, the license holder must notify the commissioner of the following in a manner prescribed by the commissioner:

(1) of the death or notification of the death of a child enrolled in the center as required under section 142B.10, subdivision 24;

(2) of the occurrence or notification of any injury to a child in care in the program that required treatment by a dentist or health care provider as defined in section 142H.01, subdivision 22. Treatment does not include application of or recommendation to use nonprescription medication or diagnostic testing;

(3) of the occurrence of structural damage to the building or a fire that requires the service of a fire department; and

(4) of the provision of any emergency medical service to a child while in care.

Sec. 29. **[142H.29] HEALTH.**

Subdivision 1. **Health policies.** An applicant must develop written health policies approved by the commissioner.

Subd. 2. **Health consultation.** (a) The center must have a health consultant as defined in section 142H.01, subdivision 23, review the center's health policies and practices in person and certify that the policies and practices are adequate to protect the health of children in care.

(b) The health consultant's review, including an on-site visit, must be done before initial licensure and must be repeated each calendar year.

(c) For programs serving infants, an in-person review must be done before initial licensure and at least quarterly thereafter. At least every other quarter, a health consultant may conduct the health review visit virtually.

(d) A health consultant must review the center's health policies and practices before implementing a change in the center's health policies or practices and after an outbreak of a contagious reportable illness as specified in Minnesota Rules, parts 4605.7040, 4605.7050, and 4605.7080.

(e) The consultant must review and approve:

(1) the emergencies, accidents, incidents, and injuries policies and procedures required by section 142H.23, subdivision 2;

(2) the diapering procedures and practices specified in subdivision 6;

(3) the programs' cleaning and disinfecting products and procedures; and

(4) the sanitation procedures and practices for food catered in or provided by the child's parent as specified in section 142H.32, subdivision 6, and for infants as specified in section 142H.32, subdivision 11.

Subd. 3. **Health information at admission.** Before a child is admitted to a center or within 30 days of admission, the license holder must obtain a report on a current physical examination of the child signed by the child's health care provider.

Subd. 4. **Immunizations.** (a) Before a child is admitted to a center, the license holder must obtain documentation of current immunization records according to section 121A.15 and Minnesota Rules, chapter 4604; a signed notarized statement of parental objection to the immunization; or a medical exemption. The license holder must maintain record of current immunizations, a signed notarized statement of parental objection to the immunization, or a medical exemption throughout the child's enrollment at the center.

(b) License holders must file an immunization report each calendar year with the Department of Health, as required under the Minnesota School and Child Care Immunization Law, section 121A.15, subdivision 8, and Minnesota Rules, part 4604.0410.

Subd. 5. **Administration of medication.** (a) A license holder that administers medication must:

(1) get written permission from the child's parent before administering medication;

(2) get written permission from the child's parent before administering items that may be applied externally, including but not limited to diapering products, sunscreen lotions, hand sanitizer, lip balm, body lotion, and insect repellents. Items under this clause must be administered according to the manufacturer's instructions unless a dentist or health care provider gives alternative written instructions;

(3) get and follow written instructions from a dentist or a health care provider before administering each prescription. Medication with the child's name and current prescription information on the label constitutes instructions;

(4) follow written dosage instructions from a child's parent or health care provider for over-the-counter medication that is intended to be ingested and does not include dosage information within the manufacturer's instructions;

(5) keep all medication in its original container and have a legible label stating the child's first and last name. The medication must be given only to the child whose name is on the label, unless as described in paragraph (b);

(6) not give medication after an expiration date on the label, return any unused portion to the child's parent if possible, and destroy any unused portion that cannot be returned;

(7) document the administration of any ingested nonprescription medication and all prescription medication. The documentation must include the first and last name of the child, name of the medication or prescription number, date, time, dosage, and printed name and signature or initials of the person who administered the medication. This documentation must be available to the parent and maintained in the child's record;

(8) store all medications, insect repellents, sunscreen lotions, and diaper rash control products according to directions on the original container and in a place inaccessible to children; and

(9) not use herbal remedies and essential oils, unless prescribed or recommended by a dentist or a health care provider. If these are administered, they must be administered in compliance with the requirements of this subdivision.

(b) Sunscreen lotions and insect repellents supplied by the license holder may be used on more than one child and must be labeled for use for all children. A product to control or prevent diaper rash, including premoistened commercial wipes that cannot be dispensed in a manner that prevents cross contamination of the product and container as determined by the health consultant, must be labeled with the child's first and last name and used only for the individual child whose name is written on the label.

Subd. 6. **Diapers, changing areas, and disposal.** Sanitary diaper procedures must be used to reduce the spread of communicable disease. A license holder must:

(1) make an adequate supply of clean diapers available for each child and store the diapers in a clean place;

(2) change diapers following the diaper changing procedure reviewed and approved by the center's health consultant pursuant to subdivision 2, paragraph (e), clause (2);

(3) post diaper changing procedures reviewed and certified by the center's health consultant in the diaper changing area;

(4) keep children in diapers clean and dry. Diapers and clothing must be changed immediately or as soon as practicable when wet or soiled. Soiled clothing must be placed in a plastic bag and sent home with the parent daily;

(5) use single-service wipes for cleaning a wet or soiled child;

(6) clean and disinfect changing tables and changing pads between children;

(7) use smooth, nonabsorbent surfaces for the diaper changing area and flooring;

(8) require the program staff person to maintain a hand on the child at all times during diapering. Children must not be left unattended on the changing table;

(9) clean and disinfect diaper changing areas, including but not limited to counters, sinks, and floors, daily or immediately when soiled;

(10) keep a covered diaper disposal receptacle lined with a disposable plastic bag in the diaper changing area. Diapers cannot be disposed of in a kitchen disposal area;

(11) empty, clean, and disinfect diaper receptacles daily or more often as needed; and

(12) only change a diaper in the diaper changing area. The diaper changing area must be separate from areas used for food storage, food preparation, and eating.

Subd. 7. **Hand washing; child.** (a) A child's hands must be washed with soap and water after a diaper change, after use of a toilet or toilet training chair, and immediately before eating a meal or snack.

(b) Program staff must monitor hand washing and assist a child who needs help.

(c) The use of a common basin or a hand sink filled with standing water is prohibited.

(d) Hands must be dried on a single-use towel or warm air hand dryer. The use of a common or shared cloth or towel is prohibited.

(e) In sinks accessible to children, the water temperature must not exceed 120 degrees Fahrenheit to prevent children from scalding themselves while washing.

(f) A hand sanitizer with at least 60 percent alcohol may be used to clean a child's hands when soap and water are unavailable.

Subd. 8. **Hand washing; program staff.** Program staff must wash their hands with soap and water after changing a child's diaper, after assisting a child on the toilet, after washing the diapering surface, after using toilet facilities, and before handling food or eating. Hands must be dried on a single-use towel or warm air hand dryer. The use of a common or shared cloth or towel is prohibited. Program staff may use a hand sanitizer with at least 60 percent alcohol when soap and water are unavailable.

Subd. 9. **First aid kit.** The license holder must have a first aid kit that is accessible in the center at all times and whenever children are off site that includes:

(1) adhesive bandages in assorted sizes and tape;

(2) sterile compresses;

(3) elastic bandage wrap;

(4) scissors;

(5) ice bag or cold pack;

(6) digital thermometer;

(7) mild liquid soap or hand sanitizer that is at least 60 percent alcohol;

(8) bottled water;

(9) disposable powder-free, latex-free gloves;

(10) face shield or protective barrier for giving CPR; and

(11) first aid instructions.

Subd. 10. **Handling and disposal of bodily fluids.** A license holder must comply with the following procedures for safely handling and disposing of bodily fluids:

(1) surfaces that come in contact with urine, feces, vomit, and blood must be cleaned and disinfected;

(2) blood-contaminated material must be disposed of in a plastic bag with a secure tie;

(3) sharp items used for a child with special care needs must be disposed of in a sharps container. The sharps container must be inaccessible to a child when stored;

(4) the license holder must have bodily fluid disposal supplies in the center, including disposable gloves, disposal bags, and eye protection; and

(5) each employee and volunteer must follow universal precautions to reduce the risk of spreading infectious disease.

Subd. 11. **Tobacco products, vaping, drugs, and alcohol use prohibitions.** (a) A license holder must comply with the drug and alcohol policy requirements in section 142B.10, subdivision 1, paragraph (c), including ensuring that no employee, subcontractor, or volunteer is under the influence of a chemical that impairs the individual's ability to provide services or care.

(b) The possession or use of marijuana, products containing THC, alcohol, and illegal drugs is prohibited on the premises of the program during operating hours, including all indoor and outdoor licensed program environments and in any vehicles used by the program.

(c) The use of tobacco products, vaping devices, and electronic cigarettes is prohibited indoors, in vehicles used by the program, and in outdoor areas where children are present.

(d) The license holder must post in a prominent location at the main entrance of the center a notice stating that use of tobacco products is prohibited inside the building and in outdoor areas where children are present.

Sec. 30. **[142H.30] ATTENDANCE RECORDS.**

Subdivision 1. **Attendance records.** A child care center must maintain documentation of actual attendance for each child receiving care. The records must be accessible to the commissioner during the program's hours of operation, be completed on the actual day of attendance, and include:

(1) the first and last name of the child;

(2) the time of day that the child was dropped off; and

(3) the time of day that the child was picked up.

Subd. 2. **Daily classroom tracking.** (a) A license holder must ensure that program staff track children in their classroom on a daily basis to ensure the center has an active roster of children present in their classroom.

(b) Children must be tracked as they arrive in and depart from the classroom.

(c) Tracking must include the first and last name of each child.

(d) The classroom tracking documentation must remain with each group at all times throughout the day including outdoor play, emergency evacuations, field trips, and when groups are combined.

Sec. 31. **[142H.31] CLEANING, SANITIZING, AND DISINFECTING.**

Subdivision 1. **Products and procedures.** Cleaning and disinfecting must be done in accordance with policies, procedures, and products approved by the program's health consultant as specified in section 142H.29, subdivision 2.

Subd. 2. **Indoor and outdoor equipment.** The indoor and outdoor space and equipment of the program must be clean.

Subd. 3. **Pacifiers.** Pacifiers must be labeled with each child's name or other individual identifier and stored separately.

Subd. 4. **Cleaning frequency.** The license holder must develop and follow a cleaning schedule that requires:

(1) cleaning and sanitizing food preparation areas, tables, high chairs, and food service counters before and after each meal and snack. Sanitizing must be done by using an Environmental Protection Agency-registered sanitizer or a bleach solution or by heating to temperatures sufficient to destroy most germs, pursuant to guidelines from the commissioner of health on infectious diseases in child care settings;

(2) cleaning and sanitizing items that have been inside a child's mouth or come into contact with bodily fluids prior to being used by another child;

(3) cleaning sleeping equipment and bedding, including:

(i) washing bedding used by a child before being used by another child;

(ii) washing bedding used by the same child weekly or when soiled;

(iii) cleaning and disinfecting sleeping equipment used by a child before being used by another child; and

(iv) cleaning and disinfecting sleeping equipment used by the same child weekly or when soiled;

(4) cleaning toileting areas daily, including:

(i) emptying and disinfecting toilet training chairs after each use; and

(ii) disinfecting toilets and seats when soiled or at least daily; and

(5) emptying garbage cans and diaper receptacles on a daily basis and cleaning and disinfecting the cans and receptacles as needed.

Sec. 32. **[142H.32] FOOD, DRINKING WATER, AND NUTRITION.**

Subdivision 1. **On-site food preparation.** A license holder that prepares, handles, or serves food or washes food, utensils, or equipment on site must comply with applicable requirements for food and beverage service establishments in chapter 157 and Minnesota Rules, chapter 4626, and local health department requirements.

Subd. 2. **Off-site food preparation.** (a) Meals or snacks may be provided by an off-site, licensed food and beverage service establishment.

(b) The center must maintain on file a copy of the off-site food and beverage service establishment's current license and the contract to provide food for the center.

Subd. 3. **Providing food.** A license holder must provide meals and snacks to the children in attendance. The license holder must supplement food provided by the parent if it does not meet United States Department of Agriculture Child and Adult Care Food Program (CACFP) nutritional requirements.

Subd. 4. **Drinking water.** (a) The center must have a safe supply of drinking water pursuant to section 142H.35.

(b) Drinking water must be available to children throughout the hours of operation and offered at frequent intervals. Drinking water for children must be provided in single-service drinking cups, in reusable water bottles, in reusable cups, or from drinking fountains accessible to children.

(c) A license holder may provide drinking water to a child in a reusable water bottle or reusable cup if the center develops and ensures implementation of a written policy that at a minimum includes the following procedures:

(1) each day the water bottle or cup is used, the license holder must clean the water bottle or cup or allow the child's parent to bring the water bottle or cup home to clean it;

(2) a water bottle or cup must be assigned to a specific child and labeled with the child's first and last name;

(3) water bottles and cups must be stored in a manner that reduces the risk of a child using the wrong water bottle or cup; and

(4) a water bottle or cup must be used only for water.

Subd. 5. **Menus.** The license holder must ensure:

(1) meals and snacks prepared or provided by the license holder or catered by a licensed food and beverage caterer comply with the meal pattern and nutritional requirements contained in the most current edition of the CACFP standards in Code of Federal Regulations, title 7, section 226.20;

(2) menus comply with the meal pattern and nutritional requirements contained in the most current edition of the CACFP standards in Code of Federal Regulations, title 7, section 226.20;

(3) the current menu is posted or made readily available to parents; and

(4) any food substitutions are noted on the menu at the time of the change.

Subd. 6. **Sanitation.** (a) Procedures for preparing, handling, storing, and serving food and washing food, utensils, and equipment must comply with the requirements for food and beverage establishments in Minnesota Rules, chapter 4626.

(b) If the food is prepared off site by another facility or if food service is provided according to a contract with a food service provider, the facility or license holder must ensure that food is prepared in compliance with Minnesota Rules, chapter 4626.

(c) The license holder must provide refrigeration for dairy products and other perishable foods, whether supplied by the license holder or supplied by the parent. The refrigeration must have a temperature of 41 degrees Fahrenheit or less.

Subd. 7. **Meals and snacks.** Except for infants under subdivision 11, the license holder must serve meals and snacks to children as follows:

(1) one snack for a child in attendance for two to five hours;

(2) one meal and two snacks or two meals and one snack for a child in attendance for five to ten hours;

(3) a minimum of two meals and two snacks for a child in attendance for more than ten hours; and

(4) a minimum of three meals and two snacks for a child in attendance for more than 14 hours.

Subd. 8. **Prescribed diet requirements.** (a) If a child is unable to follow the CACFP meal pattern requirements due to a diet-related medical condition, a prescribed diet accommodation is required.

(b) The license holder must obtain documentation from the child's health care provider about the child's special dietary needs and keep that information current. The license holder must use this information to accommodate the child's dietary needs.

(c) When a license holder enrolls a child who requires a prescribed diet, the license holder must ensure that an individual child care program plan is developed and maintained in the child's record, pursuant to sections 142H.15, subdivision 3, and 142H.27.

(d) The license holder must provide for a child's prescribed dietary needs or require the parent to provide the prescribed diet items that are not part of the center's menu plan.

Subd. 9. **Cultural or religious diet accommodations.** (a) When special diets are requested for cultural or religious reasons, the center must obtain written, dated, and signed instructions from the child's parent on how to accommodate the diet.

(b) The license holder must provide for a child's special diet for cultural or religious reasons or require the parent to provide the food items that are not part of the center's menu plan.

Subd. 10. **Food allergy information.** Information about food allergies of the children in the center must follow the requirements in section 142H.15, subdivision 5.

Subd. 11. **Infant food and feeding schedule.** The diet and feeding schedule of an infant must be determined by the infant's parent. The license holder of a center serving infants must:

(1) obtain written dietary instructions from the parent of the child that are used to develop the infant's feeding schedule and are updated as needed as the child's feeding needs change;

(2) have each individual infant's feeding schedule available in the food preparation area;

(3) offer the child formula or milk and nutritionally adequate solid foods in quantities at specified time intervals as determined by the parent;

(4) ensure infants are held or fed sitting up for bottled feedings. A bottle must not be propped at any time for an infant or fed to an infant in a crib, infant seat, or playpen;

(5) use sanitary procedures and practices to prepare, handle, and store formula, milk, breast milk, solid foods, and supplements, including having procedures to ensure bottles are matched to the correct infant. Procedures must be reviewed and certified by a health consultant;

(6) not warm or heat bottles in a microwave;

(7) not allow children access to bottle-warming devices; and

(8) label all bottles, breast milk, or prepared parent-provided food with the child's first and last name and date of preparation. All formula must be refrigerated immediately after preparation or upon arrival if the formula is prepared by the parent.

Subd. 12. **Additional requirements.** (a) The center must serve food that is not a choking hazard and that is developmentally appropriate in size, amount, and texture.

(b) Program staff must be seated with the children during meal and snack times.

Sec. 33. **[142H.33] TRANSPORTATION AND FIELD TRIP REQUIREMENTS.**

Subdivision 1. **Requirements.** A license holder that provides transportation for children or that takes children off site must comply with the requirements in this section.

Subd. 2. **Driver requirements.** (a) A driver who transports children for a license holder must:

(1) be at least 18 years old;

(2) hold a current and valid driver's license appropriate to the vehicle used to transport children;

(3) have a copy of the driver's current driver's license on file at the center;

(4) be free from the influence of any substance that could impair driving abilities; and

(5) follow seat belt and child passenger restraint system requirements under sections 169.685 and 169.686.

(b) Parents who are not employed by the center who use personal vehicles for transportation to occasional field trips do not have to meet the requirements of paragraph (a), clause (3). For the purposes of this subdivision, "occasional" means three or fewer times per calendar year.

Subd. 3. **Requirements during transportation.** (a) One program staff is required per vehicle when transporting school-age children. Two program staff are required per vehicle when transporting infants, toddlers, and preschoolers. An additional program staff person

is required in the vehicle if there are 12 or more infants and toddlers. The driver of the vehicle is considered a program staff person, unless the driver is employed by a contractor or third party.

(b) A two-way communication system and first aid kit must be present in the vehicle during transportation.

(c) Once children have exited, the vehicle must be checked to ensure that no child has been left in the vehicle.

(d) When the license holder provides transportation to and from the center, children must not be transported more than one hour per one-way trip.

(e) When children board or exit the vehicle, the license holder must ensure that each child safely boards and exits the vehicle from the curb side of the street whenever physically possible and out of the path of moving vehicles.

(f) Drop off or pick up must be conducted in a safe manner with supervision by the program staff responsible for the child.

Subd. 4. **Field trip requirements.** (a) For the purposes of this section, a field trip is defined as any time the center takes children off the property, including routine outings such as walking around the neighborhood. A center providing transportation for children to and from the center is not considered a field trip.

(b) Staff-to-child ratios must be maintained on all field trips.

(c) Written permission must be obtained from each child's parent before taking a child on a field trip. The written permission form must be obtained before each field trip or on a form that yearly summarizes all field trips that will be taken. The permission forms must be kept on file at the center.

(d) The parent's written permission form must include:

(1) the date and destination of the field trip;

(2) the times of departure from and return to the facility;

(3) the method of transportation; and

(4) if the method of transportation is walking, an estimated total distance of the walk.

(e) Unscheduled neighborhood walks may be taken, provided the program has obtained advance written parental permission for the general plan for neighborhood walks.

(f) When centers take children on a walk or field trip, program staff must bring:

(1) a first aid kit as required under section 142H.29, subdivision 9;

(2) a child's allergy information as required under section 142H.15, including the individual child care program plan;

(3) the name and telephone number of each child's parent and at least one emergency contact person;

(4) medication and supplies needed for a child who has a health condition that could need medication, special procedures, or precautions during the course of the trip; and

(5) a working cell phone or other means of immediate communication.

Sec. 34. **[142H.34] FACILITY.**

Subdivision 1. **Occupancy designation.** (a) At initial licensure, an applicant must demonstrate compliance with the standards specified by the State Building Code and any applicable local building ordinances.

(b) Prior to the child care facility being remodeled, substantially improved, renovated, or reconstructed, the license holder must verify whether approval from the applicable state or local building officials is needed. If needed, the license holder must obtain written verification of compliance with the State Building Code and any applicable local building ordinances.

Subd. 2. **Fire inspection.** (a) The center must be inspected by a fire marshal within 12 months prior to initial licensure. The commissioner must not grant an initial license until receiving written approval of compliance with the State Fire Code from the fire marshal with jurisdiction.

(b) The center must have a fire inspection at least once every five calendar years from the date of the last fire inspection report. The fire inspection must include written approval of compliance with the State Fire Code from the fire marshal with jurisdiction.

(c) Prior to the use of any areas of the structure not previously inspected and approved for child care use, the center must:

(1) receive written confirmation from the state fire marshal that approval from the state fire marshal is not needed; or

(2) conduct a fire inspection, which must include written approval of compliance with the State Fire Code from the fire marshal with jurisdiction.

(d) For centers holding a valid license as of July 1, 2027:

(1) centers initially licensed before January 1, 1998, must meet the requirement under paragraph (b) no later than July 1, 2029;

(2) centers initially licensed on or after January 1, 1998, but before January 1, 2013, must meet the requirement under paragraph (b) no later than July 1, 2030;

(3) centers initially licensed on or after January 1, 2013, but before January 1, 2021, must meet the requirement under paragraph (b) no later than July 1, 2031; and

(4) centers initially licensed on or after January 1, 2021, must meet the requirement under paragraph (b) no later than July 1, 2032.

(e) Centers that have already completed a fire inspection within five years of July 1, 2027, are exempt from paragraph (d).

Subd. 3. **Reinspection for cause.** If the commissioner has reasonable cause to believe that a potential hazard exists or the license holder is operating out of compliance with applicable codes, the commissioner may request another inspection and written report by a fire marshal, building official, or health authority.

Subd. 4. **Facility floor plan and designated areas.** (a) Indoor and outdoor space to be used for child care must be designated on a facility floor plan.

(b) Space designated on a facility floor plan must be exclusively used for child care by the center during the hours of operation.

(c) The initial application for licensure and the center's administrative record must contain a floor plan of the center. Precise scale drawings are not required. The plan must indicate:

(1) the dimensions and location of all areas of the center designated for the provision of child care including planned use of each area; and

(2) the size and location of areas used for outdoor activity.

Subd. 5. **Child's personal storage space.** A center must have storage space for each child's clothing and personal belongings. The space must be at a height appropriate for the age of the child.

Subd. 6. **Space for children who become sick.** (a) Space must be provided in the center for a child who becomes sick at a center not licensed to operate a sick care program under section 142H.19.

(b) The space must be separate from activity areas used by other children but may still be within the classroom.

(c) A cot, mat, or crib and blanket must be provided as appropriate to the developmental level of the child.

(d) The space must be supervised by a program staff person when occupied by a sick child.

Subd. 7. **Outdoor learning environment and play space.** (a) A center must provide or have available an outdoor activity area that complies with this subdivision unless licensed to exclusively provide night care as specified under section 142H.16, licensed to provide drop-in care as specified under section 142H.17, licensed to provide sick care as specified under section 142H.19, or operating for fewer than three hours a day.

(b) A center must have an outdoor activity area of at least 1,500 square feet, and there must be at least 75 square feet of space per child within the outdoor play area at any given time during use.

(c) The outdoor activity area must be enclosed if it is located adjacent to a hazard, including but not limited to traffic, rail, water, or machinery, unless the area is a public park or playground.

(d) An outdoor activity area used daily by children under school age must be within 2,000 feet of the center or transportation must be provided by the license holder. The outdoor activity area must not be farther than one-half mile from the center.

(e) The area must contain the outdoor equipment required under section 142H.14.

(f) The play area must be free of potential hazards, including but not limited to broken glass, toxic materials, machinery, unlocked vehicles, feces, and sewage contaminants.

(g) An energy-absorbing surface is required under climbing equipment, swings, and slides. An energy-absorbing surface can be loose sand, pea gravel, or mulch in a depth of at least nine inches; any material that meets ASTM F1292 specifications; or shredded rubber and poured energy-absorbing surfacing installed to manufacturer's specifications based on the height of the equipment. A fall zone is required around the equipment.

(h) When a program utilizes natural features for outdoor play, program staff members must remove hazardous objects as specified in subdivision 17 and mitigate hazards whenever possible from the surrounding area where children might fall.

Subd. 8. **Indoor space.** A center must have a minimum of 35 square feet of indoor space available per child in attendance. Hallways, stairways, closets, utility rooms, restrooms, kitchens, and space occupied by cribs are not indoor space for the purposes of this

subdivision. Twenty-five percent of the space occupied by furniture or equipment used by staff or children may be counted as indoor space.

Subd. 9. **Shielding of hot surfaces.** Heating appliances must be installed and maintained in accordance with the manufacturer's instruction and the State Building Code. Radiators, fireplaces, hot pipes, and other hot surfaces in areas used by children must be shielded or insulated to prevent burns.

Subd. 10. **Electrical outlets.** Except in a center that serves only school-age children, electrical outlets must be tamper proof or shielded when not in use.

Subd. 11. **Water hazards.** Bodies of water within or adjacent to the center must be inaccessible to children. When using a pool or beach, children must be supervised at all times.

Subd. 12. **Room temperature.** An indoor temperature of 68 degrees Fahrenheit to 82 degrees Fahrenheit must be maintained in all rooms used by children.

Subd. 13. **Hazardous areas.** Kitchens, stairs, and other hazardous areas must be inaccessible to children except during periods of supervised use.

Subd. 14. **Fire extinguisher inspection.** Fire extinguishers must be serviced by a qualified inspector at least once every 365 days. The name of the inspector and date of the inspection must be written on a tag attached to the extinguisher.

Subd. 15. **Toilet articles.** As needed, a license holder must provide and make available toilet paper, liquid hand soap, facial tissues, and single-use paper towels or warm air hand dryers.

Subd. 16. **Toilets and hand sinks.** (a) The center must have at least one hand sink for every 15 children in the center's licensed capacity.

(b) The center must have at least one toilet for every 15 children, excluding infants, in the center's licensed capacity. Toilet training chairs may be used for toddlers in lieu of a toilet.

(c) The center must provide handwashing sinks within three feet of the diaper changing surface. The sink must have hot and cold running water. In newly constructed centers or those undergoing major remodeling to the plumbing system, foot- or wrist-operated sinks must be provided in the diaper changing area.

(d) Any hand sink required for children other than infants must be in the toilet area. The temperature of hot water in the hand sinks used by children must not exceed 120 degrees

Fahrenheit. Hand sinks for children must not be used for custodial work or food preparation, including preparing infant bottles. Single-service towels or air dryers must be available to dry hands and designed for easy use by children.

(e) Toilets, sinks, faucets, and hand-drying devices in the toilet area used by children under school age other than infants must be placed at a height appropriate to the ages of the children. A sturdy nonslip platform on which children may stand may be used to meet the height requirement in this paragraph for toddlers and preschoolers.

(f) Plungers and toilet-cleaning devices must be inaccessible to children.

Subd. 17. **Hazardous objects.** (a) The license holder must prevent children from accessing hazardous objects, including any item that could reasonably cause injury, choking, poisoning, burning, cutting, or other harm to a child, or any item designated by the manufacturer to be stored out of reach of children.

(b) Activities that are part of the program plan may include the use of hazardous objects when supervised by program staff.

(c) Supplies and materials used by children must be labeled "nontoxic" by the manufacturer.

Subd. 18. **Telephone.** (a) A working telephone that is capable of making outgoing calls and receiving incoming calls must be located within the licensed child care center at all times. The telephone must be accessible to staff as needed and be sufficiently charged for use at all times.

(b) Program staff must have access to a working telephone while providing care and supervision to children in care outside of the child care facility.

Subd. 19. **Animals.** A license holder must:

(1) keep each animal housed in the program up to date on vaccines and maintain documentation of vaccinations as appropriate;

(2) notify parents prior to their child's enrollment of the presence of animals in the program, before new animals are housed, and prior to any animals visiting the program;

(3) not let children handle animals without adult supervision; and

(4) notify the parent of a child whose skin is broken by an animal bite or scratch or who is otherwise injured by an animal in writing of the injury.

Subd. 20. **Pest control.** (a) Effective measures must be taken to protect the center against rodents and insects. If rodents, insects, or other pests are found, the license holder must take

steps to remove or exterminate them. Chemicals, baits, and traps for insect and rodent control must not be used in areas accessible to children when children are present and must be used according to the manufacturer's instructions.

(b) Chemicals to control weeds, rodents, insects, and other pests must be used only after other means have been used for control, such as eliminating harborages, removing access to food, and sealing points of entry. These compounds must be used according to labeled instructions. If chemicals are used, the license holder must notify the parents of enrolled children what pesticide will be applied and where it will be applied no less than 48 hours before application, unless in cases of emergency. Only approved, United States Environmental Protection Agency-registered insecticides, rodenticides, and herbicides may be used. Application must strictly follow all label instructions and must be authorized by the director.

Subd. 21. **Posting license.** A license holder must post the license in a clearly visible place within the child care center that is accessible to parents and guardians.

Sec. 35. **[142H.35] ENVIRONMENTAL HEALTH.**

Subdivision 1. **Water supply.** A child care center must have a safe water supply. Child care centers that obtain water from privately owned wells or sources must test any water used for cooking or drinking by a Department of Health-certified laboratory to verify safety. License holders must follow the lead testing requirements in section 145.9273.

Subd. 2. **Radon testing.** (a) The license holder must notify parents whether radon testing has been conducted in the program upon enrollment and within 30 days of any subsequent testing done after enrollment.

(b) When notifying parents, the license holder must use a form prescribed by the commissioner. The notice must include information from the Department of Health about what radon is and the potential risks associated with radon exposure. If testing has been completed, the notice must include:

(1) the date of the most recent test;

(2) the rooms or areas tested; and

(3) the detected radon level or levels, stated in picocuries per liter.

(c) A license holder must keep a copy of the most recent notice to parents and the radon test results on site and make the notice and results available to parents and the commissioner

upon request. The provider may meet this requirement by posting the radon testing results in a conspicuous place.

Sec. 36. **[142H.36] MALTREATMENT OF MINORS INTERNAL REVIEW.**

If a license holder has reason to know that an internal or external report of alleged or suspected maltreatment has been made, the license holder must:

(1) establish and maintain policies and procedures to ensure that an internal review is completed within 30 calendar days and that corrective action is taken if necessary to protect the health and safety of children in care. The review must include an evaluation of whether:

(i) related policies and procedures were followed;

(ii) the policies and procedures were adequate;

(iii) there is a need for additional staff training;

(iv) the reported event is similar to past events with the children or the services involved; and

(v) there is a need for corrective action by the license holder to protect the health and safety of children in care;

(2) develop, document, and implement a corrective action plan designed to correct any current lapses and prevent future lapses in performance by individuals or the license holder, based on the results of the review;

(3) identify the primary and secondary person or position who will ensure that, when required, internal reviews are completed. The secondary person must be involved when there is reason to believe that the primary person was involved in the alleged or suspected maltreatment; and

(4) document and make internal reviews accessible to the commissioner immediately upon the commissioner's request. For the purposes of this section, the documentation provided to the commissioner by the license holder may consist of a completed checklist that verifies completion of each of the requirements of the review.

Sec. 37. Minnesota Statutes 2024, section 245A.211, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** This section applies to all programs licensed or certified under this chapter, chapters 142C, 142H, 142I, 245D, 245F, 245G, and sections 245I.20 and 245I.23. The requirements in this section are in addition to any applicable requirements for the use of holds or restraints for each license or certification type.

Sec. 38. **REVISOR INSTRUCTION.**

(a) The revisor of statutes must renumber Minnesota Statutes, section 142B.68, as Minnesota Statutes, section 142H.37.

(b) The revisor of statutes must make any necessary changes to statutory cross-references to reflect the changes in this article.

(c) The revisor of statutes must replicate the statutory history for all sections and subdivisions repealed and reenacted in this article.

Sec. 39. **REPEALER.**

(a) Minnesota Rules, parts 9503.0005; 9503.0010; 9503.0015; 9503.0030; 9503.0031; 9503.0032; 9503.0033; 9503.0034; 9503.0040; 9503.0045; 9503.0050; 9503.0055; 9503.0060; 9503.0065; 9503.0070; 9503.0075; 9503.0080; 9503.0085; 9503.0090; 9503.0095; 9503.0100; 9503.0105; 9503.0110; 9503.0115; 9503.0120; 9503.0125; 9503.0130; 9503.0140; 9503.0145; 9503.0150; 9503.0155; and 9503.0170, are repealed.

(b) Minnesota Statutes 2024, sections 142B.01, subdivisions 11, 12, 25, 26, and 27; 142B.41, subdivisions 6, 7, 10, 11, 12, and 13; 142B.54, subdivisions 1, 2, and 3; 142B.65, subdivisions 1, 2, 3, 4, 5, 6, 7, and 10; and 142B.66, subdivisions 1, 2, 4, and 5, are repealed.

(c) Minnesota Statutes 2025 Supplement, sections 142B.65, subdivisions 8 and 9; and 142B.66, subdivision 3, are repealed.

Sec. 40. **EFFECTIVE DATE.**

This article is effective July 1, 2027.

ARTICLE 7
FAMILY CHILD CARE LICENSING MODERNIZATION

Section 1. **[142I.01] DEFINITIONS.**

Subdivision 1. **Scope.** For the purposes of this chapter, the terms in this section have the meanings given.

Subd. 2. **Accessible to children.** "Accessible to children" means capable of being reached or used by a child without the aid of an adult.

Subd. 3. **Accredited.** "Accredited" means a postsecondary institution or technical college recognized and listed in the database of accredited postsecondary institutions and programs maintained by the federal Department of Education.

Subd. 4. **Adult.** "Adult" means a person at least 18 years of age.

Subd. 5. **Age categories.** (a) "Newborn" means a child from birth up to six weeks old.

(b) "Infant" means a child who is at least six weeks old but less than 12 months old.

(c) "Toddler" means a child who is at least 12 months old but less than 24 months old.

(d) "Preschooler" means a child who is at least 24 months old but less than five years of age.

(e) "School age" means a child who is at least five years of age but is less than 11 years of age.

Subd. 6. **Agency.** "Agency" means a county or multicounty social or human services agency governed by a county board or a multicounty human services board.

Subd. 7. **Annual or annually.** "Annual" or "annually" means at least once each calendar year.

Subd. 8. **Applicant.** "Applicant" has the same meaning as section 142B.01, subdivision 4.

Subd. 9. **Behavior guidance.** "Behavior guidance" means an ongoing process whereby caregivers offer constructive, positive, and developmentally appropriate guidance to children to help them manage their own behavior in a socially acceptable manner.

Subd. 10. **Bodily fluid.** "Bodily fluid" means urine, feces, vomit, blood, and other bodily fluids with blood present.

Subd. 11. **Building official.** "Building official" means the person appointed pursuant to section 326B.133 to administer the State Building Code or the building official's authorized representative.

Subd. 12. **Caregiver.** "Caregiver" means the license holder, primary provider of care, second adult caregiver, intermittent caregiver, helper, or substitute.

Subd. 13. **Child.** "Child" means a person receiving child care services who falls within the age categories in subdivision 5.

Subd. 14. **Child care.** "Child care" means the care of a child in a family child care program. This includes the children of the license holder and any other caregivers in the family child care program who receive child care during child care hours.

Subd. 15. **Child with special health care needs or disabilities.** "Child with special health care needs or disabilities" means a child who:

(1) has developmental disabilities or is otherwise eligible for case management as specified in Minnesota Rules, parts 9525.0004 to 9525.0036;

(2) has been identified by the local school district as a child with a disability as specified in section 125A.02, subdivision 1; or

(3) has been determined to be a child with a disability by a health care provider as defined in subdivision 25.

Subd. 16. **Clean.** "Clean" means free from dirt or other contaminants that can be detected by sight, smell, or touch.

Subd. 17. **Commissioner.** "Commissioner" means the commissioner of children, youth, and families.

Subd. 18. **Community-based family child care program.** "Community-based family child care program" means a family child care program that operates at a location other than the primary residence of the license holder.

Subd. 19. **Department.** "Department" means the Department of Children, Youth, and Families.

Subd. 20. **Disinfect.** "Disinfect" means the chemical process to kill most germs and viruses on surfaces and objects after the surfaces and objects have been cleaned.

Subd. 21. **Emergency replacement.** "Emergency replacement" means an adult who supervises children in a family child care program due to an emergency and who has not completed the training requirements under this chapter or the background study requirements under chapter 245C.

Subd. 22. **Family child care program.** "Family child care program" means a child care program licensed under this chapter and chapter 142B operating from the license holder's residence or other approved space that serves up to 18 children and is provided for less than 24 hours a day.

Subd. 23. **Fire marshal.** "Fire marshal" means the person designated by section 299F.011 to administer and enforce the State Fire Code or a local fire code inspector approved by the fire marshal.

Subd. 24. **Hazardous materials.** "Hazardous materials" means any item that could reasonably cause injury, choking, poisoning, burning, cutting, or other harm to a child, or any item designated by the manufacturer to be stored out of reach of children.

Subd. 25. **Health care provider.** "Health care provider" means a physician or physician's assistant licensed to practice medicine under chapter 147; an advanced practice registered nurse licensed under section 148.171; or a licensed psychiatrist, licensed psychologist, or licensed consulting psychologist.

Subd. 26. **Helper.** "Helper" means a minor, 14 through 17 years of age, who assists an adult caregiver with the care of children.

Subd. 27. **Inaccessible to children.** "Inaccessible to children" means not capable of being reached or utilized by a child without the aid of an adult.

Subd. 28. **Intermittent caregiver.** "Intermittent caregiver" means an adult who cares for children in a family child care program alongside another adult caregiver for a cumulative total of no more than 500 hours annually.

Subd. 29. **License.** "License" has the meaning given in section 142B.01, subdivision 16.

Subd. 30. **License holder.** "License holder" has the meaning given in section 142B.01, subdivision 17, for a family child care program.

Subd. 31. **Licensed capacity.** "Licensed capacity" means the total number of children ten years of age or younger permitted at any one time on the premises of a family child care program. All children ten years of age or younger on the premises count toward the capacity of the family child care program.

Subd. 32. **Medication.** "Medication" means any substance or preparation that is used to prevent or treat a wound, injury, infection, or disease; maintain health; heal; or relieve pain, including substances purchased over the counter or prescribed by a health care provider or dentist. Medication includes substances taken internally or applied externally.

Subd. 33. **Owner or renter.** "Owner" or "renter" means the individual, individuals, organization, or government entity listed in the property title, deed, lease, or equivalent legal document.

Subd. 34. **Parent.** "Parent" means a person who has the legal responsibility for a child, such as the child's mother, father, or legally appointed guardian.

Subd. 35. **Pests.** "Pests" means any animals, insects, or other living creatures that are not housed within the family child care program and are considered harmful or detrimental to the health, safety, and well-being of individuals within a family child care program. This includes but is not limited to ants, rodents, cockroaches, bedbugs, or bats.

Subd. 36. **Pets.** "Pets" means all animals housed at the family child care program or that have contact with children.

Subd. 37. **Premises.** "Premises" means the indoor and outdoor space in which a family child care program is located.

Subd. 38. **Primary provider of care.** "Primary provider of care" means the person responsible for providing care to children during the hours of operation and operating a family child care program in compliance with all applicable laws and regulations under this chapter and chapters 142B and 245C. All individual license holders are primary providers of care, as are individuals designated under section 142I.22, paragraph (f).

Subd. 39. **Radon testing.** "Radon testing" means the measurement of radon gas levels in the indoor air of the building.

Subd. 40. **Related.** "Related" means any of the following relationships by marriage, blood, or adoption: a spouse, a parent, an adoptive parent, a birth or adopted child or stepchild, a stepparent, a stepbrother, a stepsister, a niece, a nephew, a grandparent, a grandchild, a sibling, an aunt, an uncle, or a legal guardian.

Subd. 41. **Second adult caregiver.** "Second adult caregiver" means an adult who cares for children in the family child care program for a cumulative total of more than 500 hours annually along with the primary provider of care or substitute caregiver.

Subd. 42. **Separation.** "Separation" is a form of behavior guidance that involves interruption of unacceptable behavior by the removal of a child from a situation with the intention of allowing the child an opportunity to pause and gain self-control. During a separation a child is not allowed to participate in activities with other children.

Subd. 43. **State Building Code.** "State Building Code" means the codes and regulations adopted by the commissioner of administration pursuant to section 326B.107 and contained in Minnesota Rules, chapter 1300.

Subd. 44. **State Fire Code.** "State Fire Code" means the codes and regulations adopted by the state fire marshal pursuant to section 299F.011 and contained in Minnesota Rules, chapter 7511.

Subd. 45. **Substitute.** "Substitute" means an adult who is responsible for the duties of a primary provider of care when the primary provider of care is not present at the family child care program. A substitute may not provide care for more than 500 hours per calendar year.

Subd. 46. **Supervision.** "Supervision" means:

(1) caregivers must be within sight or hearing of newborns, infants, toddlers, and preschoolers at all times and must intervene in an effort to protect the health and safety of the child. Electronic monitoring devices can only be used to monitor infants, toddlers, and preschoolers when they are asleep;

(2) for a school-age child, a caregiver is available for assistance and care without the aid of a mechanical or electronic device so that the child's health and safety is protected; and

(3) the caregiver has an awareness of and responsibility for the activity of each child and is near enough to respond and reach children immediately, including responding to the child's basic needs and intervening to protect them from harm.

Subd. 47. **Variance.** "Variance" means written permission from the department pursuant to the requirements in section 142B.10, subdivision 16, for a license holder or applicant to depart from a specific requirement in this chapter or chapter 142B.

Sec. 2. **[142I.02] LICENSING OF PROGRAMS.**

Subdivision 1. **Purpose.** The purpose of this chapter is to establish procedures and standards for licensing family child care and community-based family child care programs to ensure that minimum standards of care and service are given and the protection, care, health, safety, and development of the children are assured.

Subd. 2. **Applicability.** A family child care program must be licensed under this chapter and chapter 142B to operate in Minnesota.

Sec. 3. **[142I.03] LICENSING PROCESS.**

Subdivision 1. **License application.** (a) An applicant for a family child care license must follow the requirements of this section and section 142B.10.

(b) Applicants must use the application issued by the department. The application must be made in the county where the family child care program will operate.

(c) Applicants must be the proposed license holders of the family child care program.

(d) An application for licensure is complete and ready for the agency's review after the applicant completes, signs, and submits all department forms and documentation needed for licensure to the agency and the agency receives all inspection, zoning, evaluation, and investigative reports, documentation, and information required to verify compliance with

this chapter and applicable statutes, including a completed background study for individuals subject to a study, as required under chapter 245C.

Subd. 2. **Licensing study.** (a) The applicant must give the agency access to the family child care program for a licensing study to determine compliance with all applicable rules and statutes.

(b) If the commissioner determines a potentially hazardous condition exists due to noncompliance with this chapter or local ordinances, the applicant must obtain an inspection from a fire marshal, building official, or authorized community health board agent under section 145A.04 to verify the absence of hazard or identify needed corrections. Any condition cited as hazardous and creating an immediate danger of fire or threat to life or safety must be corrected.

(c) An applicant must undergo an initial inspection of the family child care program by a fire marshal to determine compliance with the State Fire Code and compliance with orders issued if the program:

(1) has freestanding solid-fuel-heating appliances;

(2) will operate in a manufactured or mobile home;

(3) will use a basement for child care;

(4) is located in mixed- or multiple-occupancy buildings. For the purposes of this clause, "mixed-occupancy building" means a structure that contains nonresidential occupancies, such as an attached garage, and "multiple-occupancy building" means a structure with two or more residential dwelling units, such as a duplex, apartment building, or townhome; or

(5) is located in a commercial space.

Subd. 3. **Ineligibility factors.** (a) An applicant, caregiver, or any person who resides where the family child care program operates and who is present when children are in care or works with the children in care is prohibited from:

(1) abusing prescribed or nonprescribed drugs or use alcohol or controlled substances specified in chapter 152 to the extent that the use or abuse has or may have a negative effect on the ability of the primary provider of care to give care or is apparent during the hours of operation;

(2) having had a child placed in foster care within the prior 12 months for reasons that the agency determines reflect on the ability of the license holder or the primary provider of care to safely provide family child care. This clause does not apply if the primary reason

for the placement was due to a physical illness of the parent due to a disability of the child, including developmental disability of the child; or for the temporary care of a newborn or infant being relinquished for adoption;

(3) having had a child placed in a residential facility within the prior 12 months for reasons that the agency determines reflect on the ability of the license holder or the primary provider of care to safely provide family child care; or

(4) exhibiting behavior that could pose a risk to children being served in the family child care program. Additional assessments or documentation may be requested to determine the impact on the provider's ability to provide care.

(b) Caregivers who have abused prescribed or nonprescribed drugs or have been dependent on alcohol or controlled substances specified in chapter 152, such that the use, abuse, or dependency has negatively affected the ability to give care, was apparent during the hours of operation, or required treatment or therapy, must have 12 months of verified abstinence before licensure.

Subd. 4. **Variances.** The department may grant variances to this chapter.

Subd. 5. **Posting license.** The license holder must post the license in the family child care program in a location where parents, visitors, and authorized representatives of the commissioner can easily access and view the license.

Subd. 6. **Change in license terms.** A license holder must submit a new application form in accordance with section 142B.10 before:

(1) relocating the family child care program;

(2) changing the type of license from class A, C1, or C2 to C3 or C4;

(3) changing the type of license from class C3 or C4 to A, C1, or C2;

(4) changing from family child care to community-based family child care; or

(5) changing from community-based family child care to family child care.

Subd. 7. **Number of licenses.** Each individual applicant is limited to one family child care license.

Subd. 8. **Access to program.** As required in section 142B.10, subdivision 12, caregivers must give authorized representatives of the commissioner access to the family child care program premises during the hours of operation.

Subd. 9. **Disposal of license.** When a family child care program is closed, or if a license is revoked, suspended, or not renewed, the license holder must remove the license from being posted in the home within 14 days of ceasing operation or upon the final order of revocation, denial, or suspension of license; stop all advertising; and refrain from providing care to children as required in section 142B.05, subdivision 1.

Subd. 10. **Local government authority.** The authority of local units of government to establish requirements for family child care programs is limited by section 299F.011, subdivision 4a, paragraph (a), clauses (1) and (2).

Subd. 11. **Background studies.** All individuals subject to a background study must comply with the requirements of chapter 245C.

Subd. 12. **Child care license holder insurance.** (a) The license holder must complete and provide to parents a form prescribed by the commissioner that includes information about the license holder's liability insurance status. The license holder must update the form and obtain each parent's signature whenever insurance coverage changes, a policy lapses, or a new policy takes effect. If the license holder has a continuous insurance policy that renews each year, the license holder may indicate the policy's renewal date in the initial written notice to parents, and no further notices are required until the insurance coverage changes or the policy lapses.

(b) The form under this subdivision must include the date of the policy's expiration or renewal or indicate if the license holder does not carry liability insurance.

(c) A copy of the current certificate of liability insurance must be made available upon request to parents, the commissioner, and agency licensing staff.

Sec. 4. **[142I.04] AGENCY RECORDS.**

Subdivision 1. **Agency records.** An agency must maintain the following records for each license holder:

(1) a copy of the completed licensing application form signed by the applicant and the agency;

(2) a physical health report on any adult caregiver that was submitted prior to giving care in the family child care program. The physical health report must verify that the adult caregiver is physically able to care for children;

(3) any written reports from a fire marshal, building official, or agent of a community health board authorized under chapter 145A;

(4) if the applicant has been licensed through another jurisdiction, a reference from the licensing authority in that jurisdiction;

(5) the initial and annual inspection by the agency of the license holder. Any comments of the license holder about the inspections by the agency must also be noted in the agency record;

(6) a copy of the notification given to parents, prior to a child's admission, indicating that pets are present in the residence and documentation as required in section 142I.19, subdivision 4;

(7) documentation of any variance requests and the approval or denial of the request in accordance with section 142I.03; and

(8) the results of each background study required under chapter 245C.

Subd. 2. **Data privacy.** The agency, commissioner, and authorized agent as defined in section 142B.01, subdivision 5, must have access to license holder records on children in care to determine compliance with this chapter. All caregivers must maintain the privacy of records on children by refraining from discussing or disclosing any records, including electronic records, or information on children in care to any persons other than the parent of the child, the agency, the commissioner, and medical or public safety persons if the information is necessary to protect the health and safety of the child.

Sec. 5. **[142I.05] REPORTING TO AGENCY.**

Subdivision 1. **Maltreatment, abuse, and neglect reporting.** All caregivers who suspect, know, or have reason to believe a child is being or has been maltreated under section 260E.03, subdivision 12, must immediately report the information to the local welfare agency, agency responsible for assessing or investigating the report, police department, county sheriff, Tribal social services agency, or Tribal police as required by chapter 260E.

Subd. 2. **Other reporting.** Primary providers of care must notify the agency:

(1) prior to anyone moving into the residence where family child care services are provided. A background study must be completed in accordance with section 245C.13, subdivision 2;

(2) within ten calendar days after a household member has moved out of the residence where family child care services are provided;

(3) before a new caregiver provides direct contact services for the first time, unless an individual is acting as an emergency replacement according to section 142I.09, subdivision 2;

(4) of any damage to the premises that may affect compliance with this chapter or any incident at the premises that results in the loss of utility services, within 24 hours after the occurrence;

(5) within 24 hours after the occurrence of any serious injury, head injury, hospitalization, or death of a child in care. For the purposes of this clause, "serious injury" means an injury that reasonably requires the care of a health care provider or dentist; and

(6) within 24 hours after the occurrence of an animal bite in accordance with section 142I.19, subdivision 4.

Sec. 6. **[142I.06] ADMISSIONS; RECORDS; REPORTING.**

Subdivision 1. **Admission and ongoing information.** (a) Prior to admission of a child and annually while the child is enrolled, the parents and primary provider of care must discuss family child care program policies and licensing requirements.

(b) The license holder must not disclose a child's record to any person other than the child, the child's parent or guardian, the child's legal representative, employees of the license holder, and the agency unless the child's parent or guardian has given written consent or as otherwise required by law.

Subd. 2. **Statutory summary for parents.** A descriptive summary of this chapter must be distributed to the parent by the license holder at the time a child is admitted to care. The summary must be provided by the department to the agencies for distribution to license holders and must:

(1) state that this chapter and chapter 142B govern the licensing of family child care programs;

(2) specify the section headings contained in this chapter; and

(3) state that a complete copy of this chapter is available at the family child care program, agency, department, or State Law Library or through the revisor of statutes website.

Subd. 3. **Parental access.** A parent who has enrolled a child must be allowed access to the child and the licensed space at any time while the child is in care unless a court order or other legal documentation restricts access. A copy of the order or other legal documentation must be kept in the child's record at the family child care program.

Subd. 4. **Attendance records.** A license holder must maintain documentation of attendance for each child receiving care for a minimum of five years. The records must be accessible to the commissioner during the family child care program's hours of operation, must be completed on the day of attendance, and must include:

(1) the first and last name of the child;

(2) the time of day that the child was dropped off; and

(3) the time of day that the child was picked up.

Subd. 5. **License holder policies.** (a) The license holder must follow and monitor implementation of the policies and procedures by all caregivers as required in section 142B.10, subdivision 21.

(b) When applicable for the program, the license holder must have written policies available for discussion with parents and the commissioner and provide an electronic or hard copy to the parent at the time of admission or upon request. The policies must include, at a minimum:

(1) program operation policies, including:

(i) the ages and numbers of children the family child care program is licensed to serve;

(ii) the hours and days of operation, including plans for holiday closings, personal time, and policies for inclement weather closings;

(iii) fees, including payment schedule, overtime charges, and registration fees as applicable;

(iv) parental access to the family child care program that states a parent who enrolls a child must be allowed access to the child and the licensed space at any time while the child is in care;

(v) nondiscrimination practices to comply with section 142I.21;

(vi) the termination of child care and expulsion notice procedures; and

(vii) the use of a helper, a substitute for personal leave or holidays, and an emergency substitute according to the licensing requirements in section 142I.09;

(2) health and safety policies, including on:

(i) allergy prevention and response;

(ii) the administration and storage of medication and topical products;

(iii) the care of ill children, isolation precautions, symptoms for discharge and return, immunizations, medicine permission policies, and whether the license holder will care for an ill child;

(iv) disease notification procedures, including notifying the parents of exposed children within 24 hours of a parent or caregiver notifying the license holder of a reportable disease under section 142I.19, subdivision 9. The notice must be posted in a clearly visible, accessible place or provided individually to each parent of a child who was exposed;

(v) meals, snacks, infant formula, breast milk, and supplemental foods to be provided, including labeling requirements for food brought from the child's home;

(vi) sleeping and resting arrangements;

(vii) emergency procedures, fire and storm plans, and transportation in an emergency, including whether parent permission is required;

(viii) how the license holder prevents abuse of prescription medication or being in any manner under the influence of a chemical that impairs the caregiver's ability to provide services or care as required under section 142B.10, subdivision 1, paragraph (c); and

(ix) firearms at the residence in accordance with section 142I.19, subdivision 7; and

(3) program environment policies, including:

(i) behavior guidance and discipline;

(ii) field trips, including by foot, and whether parent permission is required;

(iii) the presence of pets in the family child care program, including notification prior to the introduction of a new pet to the program;

(iv) the use of screen time; and

(v) the use of social media, images, and video in accordance with subdivision 7.

Subd. 6. **Records for each child.** (a) The license holder must obtain the records in this subdivision from parents prior to the admission of a child. The license holder must keep this information up to date and on file for each child. The license holder must have a parent annually review the information in a child's record, update the information as necessary, and keep the information on file.

(b) For each enrolled child, the license holder must maintain a signed and completed admission and arrangement form, as prescribed by the commissioner, and a completed enrollment form, as developed and approved by the commissioner.

(c) Immunization records must be kept in accordance with section 121A.15 and Minnesota Rules, chapter 4604. Prior to enrollment, a license holder must request a child's immunization record. The record must be kept on file and updated as follows:

(1) for an infant, every six months;

(2) for a toddler, annually;

(3) for a preschooler, every 18 months; and

(4) for a school-age child, every three years.

(d) For each enrolled child, the license holder must obtain signed written consent from a parent allowing the license holder to obtain emergency medical care or treatment for the child.

(e) A license holder must release a child from care only to a parent or other person authorized in writing by the parent. The information must be reviewed at least annually by the parent and updated when information changes.

Subd. 7. **Social media, images, and video sharing.** (a) Caregivers are prohibited from sharing photos, videos, or other personal identifying information of enrolled children, except to provide updates to parents who have provided written consent. If a license holder wishes to use photos or videos of the family child care program and the enrolled children for promotional or publicity purposes, including on social media accounts or public digital platforms, the license holder must obtain written consent from parents prior to use.

(b) Notwithstanding paragraph (a), the license holder must share photos, videos, and other personal identifying information of enrolled children with the commissioner upon request.

Subd. 8. **Nondiscrimination.** A caregiver is prohibited from discriminating in relation to enrollment in their program based on race, color, creed, religion, national origin, sex, gender identity, marital status, disability, sexual orientation, or familial status.

Sec. 7. **[142I.07] CAPACITY AND RATIOS.**

Subdivision 1. **Capacity limits.** License holders must be licensed for the total number of children ten years of age or younger who are present on the premises of the family child care program at any one time during child care hours, including the caregiver's own children and foster children.

Subd. 2. **Capacity, ratios, and age distribution restrictions.** (a) The commissioner must issue licenses based on the capacity and ratios in this subdivision.

(b) License holders with a class A license must meet the following requirements:

Class	Capacity	Minimum Adult Caregivers	Maximum Children Under School Age	Maximum Total Infants and Toddlers	Maximum Infants
A	10	1	6	3	2

(c) License holders with a class C license must meet the following requirements:

Class	Capacity	Minimum Adult Caregivers	Maximum Children Under School Age	Maximum Total Infants and Toddlers	Maximum Infants
C1	10	1	8	4	2
C2	12	1	10	3	1
C3	14	2	10	6	4
C4	18	2	12	5	2

Subd. 3. **Newborn care.** When a newborn is in care and only one adult caregiver is present, the newborn must be the only child under 12 months of age present, and the license holder must not care for more than two other children at the same time unless the newborn is the license holder's child. When a second adult caregiver is also present or the newborn is the child of the license holder, then the newborn is considered an infant for the purposes of child-to-adult ratios and age distribution restrictions.

Subd. 4. **Supervision, primary provider of care, and use of substitutes.** (a) Children in care must be supervised by an adult caregiver. The adult caregiver must have knowledge of each child's needs, including but not limited to developmental and behavioral needs and parental preferences, and be accountable for each child's care at all times. A caregiver must be within sight or hearing of newborns, infants, toddlers, and preschoolers at all times without the use of monitoring devices, except as provided in section 142I.18.

(b) The primary provider of care must be the primary caregiver in the family child care program unless a substitute is being used in accordance with section 142I.09. A helper may be used in place of a second adult caregiver when there is no more than one newborn, infant, or toddler present.

(c) The use of a substitute caregiver must be in accordance with section 142I.09.

Subd. 5. **Overnight care.** When a family child care program has a child in care after 11 p.m. and before 5 a.m.:

(1) at least one adult caregiver must remain awake and available to respond to children's needs at all times. The program must maintain required caregiver-to-child ratios. Additional

caregivers may sleep when ratios are maintained and must be available to resume supervision when needed;

(2) all awake children must be given the opportunity to engage in age-appropriate activities in a separate room away from sleeping children; and

(3) the child care emergency plan must include a plan tailored to sleeping children.

Subd. 6. **Class C4 licenses.** (a) class C4 licenses must always operate at the level of exit discharge.

(b) A family child care program with a class C license may operate as a lower C-class level family child care program on days when the adult-to-child ratios allow it to operate at a lower capacity.

Subd. 7. **Care of the license holder's own child or children.** (a) With the license holder's consent, an individual may be present in the licensed space and care for the license holder's own child both inside and outside of the licensed space and is exempt from the training and supervision requirements of section 142I.10 if the individual:

(1) is related to the license holder or to the license holder's child, as defined in section 142I.01, subdivision 40, or is a household member who the license holder has reported to the county agency;

(2) is not a caregiver for the family child care program at the time that they are supervising the license holder's own child;

(3) only cares for the license holder's own child; and

(4) does not have direct, unsupervised contact with any nonrelative children in care.

(b) If the individual in paragraph (a) is not a household member, the individual is also exempt from background study requirements under chapter 245C.

(c) Where a caregiver is also a parent providing care to their own child in the family child care program, the commissioner must take into consideration the parent's right to direct the care, custody, and control of the parent's child when enforcing the provisions of this chapter.

(d) Notwithstanding paragraph (c), family child care programs with license holders or caregivers providing care to their own child are not exempt from the capacity, ratio, and age distribution requirements under this section. License holders and caregivers remain subject to chapters 260E and 609 and other applicable statutes and rules.

Sec. 8. **[142I.08] QUALIFICATIONS.**

Subdivision 1. **Age.** An applicant for a family child care license must be an adult at the time of application.

Subd. 2. **Physical and behavioral health.** (a) An adult caregiver must be physically and mentally able to care for children. An applicant or primary provider of care must provide documentation to the agency along with the license application verifying that the applicant has had a physical examination by a licensed physician, advanced practice registered nurse, or physician assistant within 12 months prior to the application for initial licensure and that the applicant or primary provider of care is physically able to care for children. Prior to assisting in the care of children, the applicant must also provide documentation verifying that any adult caregiver has had a physical examination by a licensed physician, advanced practice registered nurse, or physician assistant within the past 12 months and is physically able to care for children.

(b) The commissioner may require a caregiver to provide reports on the caregiver's physical or mental health from a health care provider when there is reason to believe that a caregiver exhibits physical or mental health symptoms that could impair the caregiver's ability to ensure the health and safety of children. The reports must not be used for any other purpose than to determine whether the caregiver's physical or mental health impacts the health and safety of children.

Subd. 3. **Additional class C3 and C4 license requirements.** (a) An applicant or primary provider of care receiving a class C3 or C4 license must have at least one of:

(1) a minimum of one year of substantial compliance with this chapter as a Minnesota-licensed family child care license holder, primary provider of care, or second adult caregiver and a minimum of 1500 hours of direct care in a family child care program serving children;

(2) a minimum of six months of substantial compliance with this chapter as a family child care license holder, primary provider of care, or second adult caregiver in Minnesota and:

(i) a minimum of 520 hours of experience as an assistant teacher, student teacher, or intern in an elementary school, after-school program, or Minnesota-licensed child care center or as an adult caregiver in a Minnesota-licensed family child care program and 30 hours of child care, health, and nutrition training as specified in section 142I.10; or

(ii) a minimum of 520 hours of experience as a licensed practical or registered nurse, and 30 hours of child development or early childhood education training, as specified in section 142I.10;

(3) certification or licensure indicating completion of one of the following:

(i) a two-year child development or early childhood education associate or certificate program at an accredited college or university;

(ii) a child development associate certification;

(iii) a certification from a recognized Montessori organization;

(iv) a bachelor's degree or higher in early childhood education from an accredited college or university; or

(v) an elementary education degree from an accredited college or university that includes a minimum of 30 hours of child development training; or

(4) six months' experience working an average of 30 hours a week or more as a teacher, as defined in section 142H.06, at a Minnesota-licensed child care center.

(b) An applicant or primary provider of care must complete an additional large group training created by the commissioner as a condition of receiving a class C4 license.

Sec. 9. **[142I.09] SUBSTITUTE CAREGIVERS AND REPLACEMENTS.**

Subdivision 1. **Total hours allowed.** The use of a substitute caregiver in a family child care program is limited to a cumulative total of not more than 500 hours annually. When a substitute is used, prior to the end of each business day the license holder must document the name, date, and number of hours of each substitute who provided care.

Subd. 2. **Emergency replacement supervision.** (a) In an emergency, a license holder may allow an adult who has not completed the training requirements under this chapter or the background study requirements under chapter 245C to supervise children in a family child care program. For purposes of this subdivision, "emergency" means a situation in which the license holder has begun operating the family child care program for the day and for reasons beyond the control of the license holder, including but not limited to a serious illness or injury, accident, or situation requiring the immediate attention of the license holder, the license holder needs to leave the licensed space and close the program for the day.

(b) To the extent practicable, the license holder must attempt to arrange for emergency care by a substitute caregiver before using an emergency replacement.

(c) When an emergency occurs:

(1) the license holder or emergency replacement must contact the parents of the children attending the family child care program and inform the parents that the program is closing for the day and that the children need to be picked up as soon as practicable;

(2) the license holder must not knowingly use a person as an emergency replacement who has committed an action or has been convicted of a crime that would cause the person to be disqualified from providing care to children if a background study was conducted under chapter 245C;

(3) the license holder must make reasonable efforts to minimize the amount of time the emergency replacement has unsupervised contact with the children in care not to exceed 12 hours per emergency incident;

(4) the family child care program must be closed for the day once the last unrelated child has left the program; and

(5) the license holder must notify the county licensing agency within seven days that an emergency replacement was used and specify the circumstances that led to the use of the emergency replacement.

(d) The county licensing agency must notify the commissioner within three business days after receiving the license holder's notice that an emergency replacement was used and specify to the commissioner the circumstances that led to the use of the emergency replacement.

(e) A license holder is not required to provide the names of persons who may be used as replacements in emergencies to parents or the county licensing agency. However, once an emergency replacement has been used, the license holder must provide the name of the individual used to the county licensing agency.

Sec. 10. **[142I.10] APPLICANT, PRIMARY PROVIDER OF CARE, AND SECOND ADULT CAREGIVER TRAINING REQUIREMENTS.**

Subdivision 1. **Initial training; applicant, primary provider of care, and second adult caregiver.** (a) Before providing care, an applicant, a primary provider of care, and each second adult caregiver must have completed all required initial training within the prior 24 months.

(b) Initial training does not need to be completed before providing care in the following circumstances:

(1) a primary provider of care who voluntarily closes a license and reopens within 12 months has one year from the new license's effective date to complete annual and ongoing training and is exempt from repeating initial training;

(2) a primary provider of care who relocates within the state has until the end of the calendar year to complete annual and ongoing training and is not required to repeat initial training previously completed; and

(3) a primary provider of care who relocates to a new county must not be required by the new county to complete orientation or other training required for new applicants.

(c) Each applicant, primary provider of care, and second adult caregiver must complete and document the following before providing care:

(1) at least four hours of child development, learning, or behavior guidance training. An individual is exempt if the individual provides documentation verifying that the individual:

(i) has completed a three-credit early childhood development course within the past five years;

(ii) holds a baccalaureate or master's degree in early childhood education or school-age child care;

(iii) holds a Minnesota teaching license in early childhood education, kindergarten through grade 6, or special education; or

(iv) holds a Montessori certificate;

(2) the six-hour supervising for safety for family child care course developed by the commissioner;

(3) pediatric first aid training provided by an instructor certified to teach pediatric first aid. Current training documentation must be maintained at the family child care program and made available upon request. Online training reviewed and approved by the county licensing agency satisfies this requirement;

(4) pediatric cardiopulmonary resuscitation (CPR) training that:

(i) is instructor led or blended with a hands-on skills component. Online-only CPR courses without a hands-on component do not meet this requirement;

(ii)(A) is developed by the American Heart Association or the American Red Cross; or

(B) uses nationally recognized, evidence-based guidelines for CPR training; and

(iii) is provided by an instructor approved by the commissioner to teach CPR;

(5) for programs licensed for children younger than school age, training on reducing the risk of sudden unexpected infant death and abusive head trauma, which may be combined in a single commissioner-approved course. This training must, at a minimum, address the risk factors related to sudden unexpected infant death and abusive head trauma and the means of reducing the risk of each;

(6) training on proper use and installation of child passenger restraint systems under section 169.685 of at least one hour in length that is provided by an instructor certified and approved by the Department of Public Safety. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age and the proper installation of a car seat or booster seat in the motor vehicle used by the caregiver to transport the child or children. This requirement does not apply to family child care programs that transport only school-age children as defined in section 142I.01, subdivision 5, paragraph (e), in child care buses as defined in section 169.448, subdivision 1, paragraph (e);

(7) training on the child care emergency plan required under section 142I.19, subdivision 2;

(8) training on allergy prevention and response required under section 142I.06, subdivision 5, paragraph (b);

(9) training on the community-based family child care program plan required under section 142I.22, if applicable;

(10) training on the family child care program policies and procedures required under section 142I.06;

(11) training on reporting suspected maltreatment of children as required under chapter 260E; and

(12) swimming pool training under section 142I.14, subdivision 6, if a pool at the family child care program is used by children in care.

(d) County licensing staff must accept approved training on the primary provider of care or second adult caregiver's learning record in the Develop data system for early education and school-age care.

Subd. 2. **Annual training; primary provider of care and second adult caregiver.** (a) A primary provider of care and each second adult caregiver must annually complete and document the following training:

(1) at least two hours of child development, learning, or behavior guidance training. A three-credit early childhood development course completed within the calendar year meets this requirement;

(2) a two-hour active supervision course developed or approved by the commissioner;

(3) training on reducing the risk of sudden unexpected infant death if caring for infants and training on reducing the risk of abusive head trauma if caring for children under school age, which must:

(i) be completed in person or online at least once every two years; and

(ii) in alternating years, be completed through a commissioner-approved video not exceeding one hour in length; and

(4) at least four hours of ongoing training each calendar year that must include topics identified in the Minnesota knowledge and competency framework. Repeat of topical training requirements in subdivision 1 counts toward the annual ten-hour requirement.

(b) A caregiver who is approved as a trainer through the Develop data system may count up to two hours of training instruction toward the annual ten-hour training requirement in paragraph (a), clause (4), if:

(1) the training is the first instance in which the caregiver delivers a particular content-specific training during each training year;

(2) the caregiver is a Develop-approved active trainer; and

(3) the hours counted as training instruction are approved through the Develop data system with attendance verified on the trainer's individual learning record and are in the knowledge and competency framework content areas VII A, establishing healthy practices, or B, ensuring safety.

(c) Unless specifically authorized in this section, one training does not fulfill two different training requirements. Courses within the identified knowledge and competency areas that are specific to child care centers or legal nonlicensed programs do not fulfill the requirements of this section.

(d) County licensing staff must accept training designated by the commissioner as satisfying training requirements if the training is within the knowledge and competency framework for child development and learning, behavior guidance, and active supervision as indicated on the department's website.

Subd. 3. **Ongoing training; primary provider of care and second adult caregiver.** (a) A primary provider of care and each second adult caregiver must complete and document the following training:

(1) pediatric cardiopulmonary resuscitation training that meets the requirements of subdivision 1, paragraph (c), clause (4), and is repeated every two years within 90 days of the second anniversary of the previous training. Documentation must be maintained at the family child care program or electronically and made available upon request;

(2) pediatric first aid training by a certified instructor repeated every two years within 90 days of the second anniversary of the previous training. Documentation of the training must be maintained at the family child care program or electronically and made available upon request;

(3) commissioner-developed Health and Safety I and Health and Safety II training at least once every five years. Completion of either course in a given year meets the annual active supervision training requirement in subdivision 2, paragraph (a), clause (2);

(4) proper use and installation of child passenger restraint systems under section 169.685 that meets the requirements of subdivision 1, paragraph (c), clause (6), and is repeated at least once every five years. This requirement does not apply to family child care programs that transport only school-age children as defined in section 142I.01, subdivision 5, paragraph (e), in child care buses as defined in section 169.448, subdivision 1, paragraph (e); and

(5) fire safety training developed by the State Fire Marshal's Office that must be completed once every five years.

(b) If a license holder changes any of the policies and procedures under section 142I.06, subdivision 5, the primary provider of care and each second adult caregiver must review the revised policies and procedures within ten days of the change.

(c) The license holder must maintain documentation of each review of the revised policies and procedures at the family child care program. The documentation requirements under this paragraph may be met by a date noted on the revised policies or procedures.

Subd. 4. **Commissioner designated training.** Training designated by the commissioner satisfies the training requirements under this section if the training is within the knowledge and competency framework for child development and learning, behavior guidance, and active supervision, as indicated on the department's website.

Sec. 11. **[142I.11] SUBSTITUTE AND INTERMITTENT CAREGIVER TRAINING REQUIREMENTS.**

Subdivision 1. **Initial training; substitute and intermittent caregiver.** (a) Before providing care, each substitute and intermittent caregiver must complete the following training requirements within the previous 12 months:

(1) the four-hour basics of family child care for substitutes course developed by the commissioner;

(2) pediatric first aid training provided by an instructor certified to teach pediatric first aid. Current training documentation must be maintained at the family child care program and made available upon request. Online training reviewed and approved by the county licensing agency satisfies this requirement;

(3) pediatric cardiopulmonary resuscitation training that meets the requirements of section 142I.10, subdivision 1, paragraph (c), clause (4);

(4) for programs licensed for children younger than school age, training on reducing the risk of sudden unexpected infant death and abusive head trauma, which may be combined in a single commissioner-approved course. This training must, at a minimum, address the risk factors related to sudden unexpected infant death and abusive head trauma and the means of reducing the risk of each;

(5) training on proper use and installation of child passenger restraint systems under section 169.685 of at least one hour in length, provided by an instructor certified and approved by the Department of Public Safety. This requirement does not apply to family child care programs that transport only school-age children as defined in section 142I.01, subdivision 5, paragraph (e), in child care buses as defined in section 169.448, subdivision 1, paragraph (e). At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age and the proper installation of a car seat or booster seat in the motor vehicle used by the caregiver to transport the child or children;

(6) training on the child care emergency plan required under section 142I.19, subdivision 2;

(7) training on allergy prevention and response required under section 142I.06, subdivision 5, paragraph (b);

(8) training on the community-based family child care program plan required under section 142I.22, if applicable;

(9) training on the family child care program policies and procedures required under section 142I.06;

(10) training on reporting suspected maltreatment of children as required under chapter 260E; and

(11) swimming pool training under section 142I.14, subdivision 6, if a pool at the family child care program is used by children in care.

(b) County licensing staff must accept approved training on the substitute or intermittent caregiver's learning record in the Develop data system for early education and school-age care.

Subd. 2. **Annual training; substitute and intermittent caregiver.** (a) Substitutes and intermittent caregivers must complete a minimum of one hour of training each calendar year, and the training must include the requirements in this section.

(b) Each calendar year, a substitute or intermittent caregiver must receive training on reducing the risk of abusive head trauma from shaking infants and young children if caring for children under school age and reducing the risk of sudden unexpected infant death if caring for infants. A substitute must complete each applicable course at least once every two years either in person or online. In a year a substitute or intermittent caregiver is not completing an applicable course under this paragraph in person or online, the individual must watch a video on the respective topic of no more than one hour in length. The video must be developed or approved by the commissioner. A license holder must maintain documentation of compliance with this paragraph for each substitute and intermittent caregiver employed.

Subd. 3. **Ongoing training; substitute and intermittent caregiver.** (a) At least once every three years, a substitute or intermittent caregiver must complete the four-hour basics of family child care for substitutes course.

(b) A substitute or intermittent caregiver must complete the following training:

(1) pediatric cardiopulmonary resuscitation training that meets the requirements of section 142I.10, subdivision 1, paragraph (c), clause (4), and is repeated every two years within 90 days of the second anniversary of the previous training. Documentation must be maintained at the family child care program or electronically and made available upon request;

(2) pediatric first aid that is given by an instructor certified to provide pediatric first aid and is repeated every two years within 90 days of the second anniversary of the previous

training. Documentation of the training must be maintained at the family child care program or electronically and made available upon request; and

(3) proper use and installation of child passenger restraint systems under section 169.685 that meets the requirements of section 142I.10, subdivision 1, paragraph (c), clause (6), and is repeated at least once every five years. This requirement does not apply to family child care programs that transport only school-age children as defined in section 142I.01, subdivision 5, paragraph (e), in child care buses as defined in section 169.448, subdivision 1, paragraph (e).

Sec. 12. **[142I.12] HELPER TRAINING REQUIREMENTS.**

Subdivision 1. **Initial training; helper.** (a) Before assisting in care, a helper who assists with care must complete a minimum of four hours of training within the previous 12 months. The four hours must include courses on:

(1) reducing the risk of sudden unexpected infant death if the program is licensed to care for infants;

(2) abusive head trauma if the program is licensed to care for children younger than school age; and

(3) reporting suspected maltreatment of children as required under chapter 260E.

(b) The trainings required under paragraph (a) may be combined in a single commissioner-approved course.

(c) A license holder must maintain written or electronic documentation showing that each helper has complied with this subdivision.

Subd. 2. **Annual training; helper.** (a) Each calendar year, a helper who assists in the care of children must receive training on reducing the risk of sudden unexpected infant death if the program is licensed to care for infants, and abusive head trauma if the program is licensed to care for children younger than school age. The trainings under this paragraph may be combined in a single commissioner-approved course and must, at a minimum, address risk factors, methods of risk reduction in child care, and communication with parents regarding risk reduction.

(b) A license holder must maintain documentation showing each helper has complied with this subdivision.

(c) County licensing staff must accept approved training on the helper's learning record in the Develop data system.

Sec. 13. **[142I.13] BEHAVIOR GUIDANCE.**

Subd. 2. **Methods of promoting positive behavior.** A license holder must:

(1) positively role model acceptable behavior to each child;

(2) tailor methods of promoting positive behavior to the developmental level of the children the family child care program is licensed to serve;

(3) ensure redirection is used as appropriate in addressing a child's behavior, to guide a child away from potential challenges toward constructive activity. For the purposes of this clause, "redirection" means when a caregiver intervenes and guides a child toward constructive activity through positive techniques;

(4) teach children how to use acceptable alternatives to reduce conflict; and

(5) protect the safety and well-being of children and caregivers.

Subd. 3. **Prohibited actions.** A license holder must prohibit every caregiver from:

(1) subjecting a child to corporal or physical punishment. This includes but is not limited to rough handling, shoving, hair pulling, ear pulling, shaking, slapping, kicking, biting, pinching, spitting, hitting, and spanking;

(2) subjecting a child to name calling, ostracism, shaming, making derogatory remarks about the child or the child's family, cultural or racial slurs, and yelling or using profane language that threatens, humiliates, or frightens the child;

(3) forcing a child to maintain an uncomfortable position or to continuously repeat physical movements;

(4) separating a child from the group except as provided in subdivision 4;

(5) punishing a child for:

(i) not resting, napping, or sleeping;

(ii) toileting accidents;

(iii) failing to eat all or part of meals or snacks; or

(iv) failing to complete an activity;

(6) denying a child food or drink or forcing food or drink upon a child;

(7) denying light, warmth, clothing, or medical care as a punishment for unacceptable behavior;

(8) the use of physical restraint other than to physically hold a child when containment is necessary to protect a child or others from harm;

(9) the use of prone restraints, as prohibited by section 245A.211;

(10) the use of mechanical restraints, such as tying, or any device or equipment intended to restrict or prevent movement as a means of discipline or for reasons unrelated to the child's care, safety, or planned activity;

(11) giving a child any nonprescribed substance to subdue or restrict movement or behavior;

(12) delegating the discipline or punishment of a child to another child; and

(13) punishing or shaming a child for the actions of a parent. This includes but is not limited to failure to pay fees, failure to provide appropriate clothing, failure to provide materials for an activity, or any conflict between the license holder or caregiver and the parent.

Subd. 4. **Separation time from the group.** A caregiver must not separate a child from the child's group as a means of behavior guidance unless the caregiver has tried less intrusive methods of guiding the child's behavior that have been ineffective and the child's behavior threatens the well-being of the child or other children in the family child care program. Separation from the group must meet the following requirements:

(1) children younger than three years old must not be separated from the group as a means of behavior guidance;

(2) the separation time must be limited to the amount of time necessary for the child to gain self-control and rejoin the group while being supported by the caregiver;

(3) the child must be supervised;

(4) the child must not be placed in a locked room to separate the child from the group; and

(5) the caregiver must provide the separation time in an age-appropriate, nonhumiliating manner for the child.

Sec. 14. **[142I.14] PHYSICAL SPACE REQUIREMENTS.**

Subdivision 1. **Indoor space.** (a) The licensed capacity of the family child care program must be limited by the amount of usable indoor space available to children. A minimum of 35 square feet of usable indoor space is required per child.

(b) Bathrooms, closets, space occupied by major appliances, and other space not used by children may not be counted as usable space. Space occupied by adult furniture, if it is used by children, may be counted as usable indoor space.

(c) Usable indoor space may include a basement if it has been inspected and approved by a fire marshal, is free of hazards, and meets the requirements of subdivision 4.

(d) All exits leading from indoor to outdoor space must be fully clear of obstruction.

Subd. 2. **Escape routes.** (a) The main means of escape must be a stairway or door leading to the floor with an exit to the outside.

(b) Any room that has sleeping children must have an escape route separate from the main exit referenced in paragraph (a). This escape route must be a door or an egress window leading directly outside.

(c) When the basement is used for care, the basement must have at least one escape route separate from the main exit under paragraph (a). This escape route must be a door or an egress window leading directly outside.

(d) Required escape routes must not be obstructed and must be accessible and openable without special knowledge.

Subd. 3. **Outdoor learning environment and play space.** (a) A family child care program must have an outdoor play space of at least 50 square feet per child the program is licensed to serve for regular use or a park, playground, or play space within 1,500 feet of the family child care program.

(b) During outdoor play:

(1) the adult caregiver must remain outdoors with infants, toddlers, and preschoolers at all times;

(2) school-age children may be permitted in the approved outdoor play space at the family child care program without a caregiver if:

(i) the children are engaged in age-appropriate activities using age-appropriate equipment; and

(ii) a caregiver remains accessible to provide supervision when needed in accordance with section 142I.01, subdivision 46; and

(3) when the outdoor play space is not at the family child care program, a caregiver must accompany and supervise all children in transit and at the outdoor play space.

(c) Caregivers must prevent children from accessing hazardous materials.

(d) Outdoor play areas must be protected from traffic and nearby hazards. If traffic or other hazards are present, the family child care program must have:

(1) a continuous fence in good condition with functioning gates or a continuous natural barrier or a combination of fence and naturally occurring or landscaping barrier. The fence or natural barrier must ensure that children are not able to leave the outdoor play area unsupervised; or

(2) a supervision and safety plan if a fence is not used that includes alternative methods to ensure the health, safety, and protection of children in care.

(e) Electrical fences must be inaccessible to children in care.

(f) Caregivers must take measures to protect children from the dangers of sun exposure, extreme heat or cold, and air quality.

(g) Outdoor equipment, whether stationary or portable, must be safe, be in good repair, be assembled according to the manufacturer's guidelines, and meet the developmental needs of the age groups of children using the space.

(h) Equipment including but not limited to climbing gyms, swings, and slides must:

(1) not have openings between 3-1/2 inches and nine inches in size to prevent entrapment of the head or other body parts;

(2) have guardrails or protective barriers on platforms that are 30 inches or higher. A protective barrier is a continuous structure surrounding the platform that is designed to prevent a person from falling or passing through, whether intentionally or accidentally; and

(3) be assembled, installed, and utilized according to the manufacturer's guidelines.

Subd. 4. **Conditions of the program.** The licensed space must be maintained in a manner that protects the health and safety of children in care. The license holder must ensure that:

(1) the family child care program space is free from conditions that endanger the health or safety of children, including unsanitary conditions or excessive accumulation of materials that can start a fire or create other safety hazards;

(2) the furnishings, equipment, and materials are arranged and stored so that hallways, stairways, doors, and exit routes remain unobstructed and usable for safe exit; and

(3) the amount and placement of stored items do not create an increased risk of fire or injury or impede the safe supervision of children.

Subd. 5. **Portable wading pools.** (a) A child must not use a portable wading pool as defined in section 144.1222, subdivision 2a, at a family child care program unless the parent of the child has provided written consent. The written consent must include a statement that the parent has received and read material provided by the Department of Health on wading pool safety for parents related to the risk of disease transmission as well as other health risks associated with the use of portable wading pools.

(b) The license holder must empty wading pools daily.

(c) A caregiver must supervise children at all times while a wading pool is in use and must be able to clearly see all parts of the wading area. When not in use under the supervision of a caregiver, wading pools must be inaccessible to children.

Subd. 6. **Swimming pools.** (a) For the purposes of this subdivision, "swimming pool" has the meaning in section 144.1222, subdivision 2b, and does not include a portable wading pool as defined in section 144.1222, subdivision 2a, or a spa pool as defined in Minnesota Rules, part 4717.0250.

(b) A license holder must comply with the following requirements in order for children in the program to use a swimming pool located at the program:

(1) not have had a licensing sanction under section 142B.18 or a correction order or conditional license under section 142B.16 relating to the supervision or health and safety of children during the prior 24 months;

(2) notify the county agency before initial use of the swimming pool each calendar year;

(3) obtain written consent from a child's parent allowing the child to use the swimming pool and renew the parent's written consent at least annually. The written consent must include a statement that the parent has received and read materials provided by the Department of Health related to the risk of disease transmission as well as other health risks associated with swimming pools. The written consent must also include a statement that neither the Department of Health nor the county agency will monitor or inspect the license holder's swimming pool;

(4) attend and successfully complete a swimming pool supervision training course annually;

(5) attend and successfully complete one of the following swimming pool operator training courses once every five years:

(i) both of the National Spa and Pool Institute Tech I and Tech II courses; or

(ii) the National Recreation and Park Association aquatic facility operator course;

(6) ensure all toilet-trained children use the bathroom before the children enter the swimming pool;

(7) require all children who are not toilet trained to wear swim diapers while in the swimming pool;

(8) if fecal material enters the swimming pool water, add three times the normal shock treatment to the pool water to raise the chlorine level to at least 20 parts per million and close the pool to swimming for the 24 hours following the entrance of fecal material into the water or until the water pH and disinfectant concentration levels have returned to the standards specified in clause (10), whichever is later;

(9) prevent any person from entering the swimming pool who has an open wound or has or is suspected of having a communicable disease;

(10) maintain the swimming pool water at a pH of not less than 7.2 and not more than 8.0, maintain the disinfectant concentration between two and five parts per million for chlorine or between 2.3 and 4.5 parts per million for bromine, and maintain a daily record of the swimming pool's operation with pH and disinfectant concentration readings on days when children cared for at the family child care program are present;

(11) have a disinfectant feeder or feeders;

(12) have a recirculation system that will clarify and disinfect the swimming pool volume of water in ten hours or less;

(13) maintain the swimming pool's water clarity so that an object on the pool floor at the pool's deepest point is easily visible;

(14) comply with the provisions in section 144.1222, subdivisions 1c and 1d;

(15) have in place and enforce written safety rules and swimming pool policies;

(16) have in place at all times a safety rope that divides the shallow and deep portions of the swimming pool;

(17) maintain compliance with any existing local ordinances regarding swimming pool installation, decks, and fencing;

(18) maintain a water temperature of not more than 104 degrees Fahrenheit and not less than 70 degrees Fahrenheit;

(19) cover the swimming pool when not in use;

(20) follow the requirements of subdivision 7; and

(21) for lifesaving equipment, have a United States Coast Guard-approved life ring attached to a rope, an exit ladder, and a shepherd's hook available at all times to the caregiver supervising the swimming pool.

Subd. 7. **Water hazards.** (a) Swimming and wading pools, beaches, wells, or other bodies of water on or adjacent to the site of the family child care program must be inaccessible to children except during periods of supervised use.

(b) All water hazards, such as inground or aboveground swimming pools, hot tubs, stationary wading pools, fish ponds, and water retention or detention basins on the site of the family child care program must be enclosed with a permanent fence, wall, building wall, other physical barrier, or combination thereof that is at least four feet in height. A house exterior wall can constitute one side of a fence if the wall has no openings capable of providing direct access to the hazard, including but not limited to doors or windows.

(c) The family child care program may not allow a child in care to use a swimming pool or beach without an adult caregiver trained in first aid and CPR present.

(d) Bodies of water must be separated from the play area by a fence or other physical barrier that prevents children from accessing the water. The house door alone is not a sufficient barrier.

Subd. 8. **Water play.** (a) Parental permission is not required for children to use splash pads, sprinklers, or other water toys that spray or jet water on the users and do not have standing water. Splash pads, sprinklers, or other water toys that retain water are considered wading pools and are required to meet the requirements of subdivision 5.

(b) Water tables designed for children to play with their hands must be emptied daily. The caregiver must supervise children at all times while a water table is in use and must be able to clearly see all parts of the water table. When not in use under the supervision of a caregiver, water tables must be inaccessible to children.

Subd. 9. **Separation between attached garage and family child care program.** The separation wall between the residence and garage must meet the requirements of Minnesota Rules, part 1309.0302.

Subd. 10. **Ventilation, heating, and cooling systems.** (a) Heating, ventilation, and air conditioning systems must be operated according to the manufacturer's instructions and in good repair. Gas, coal, wood, kerosene, or oil heaters must be vented to the outside in accordance with the State Building Code.

(b) Items that can be ignited and support combustion, including but not limited to plastic, fabric, and wood products, must not be located within:

(1) 18 inches of a gas or fuel-oil heater or furnace; or

(2) 36 inches of a solid-fuel-burning appliance.

(c) If a license holder produces manufacturer instructions listing a distance closer than the requirements under paragraph (b), the manufacturer instructions control the required distance of combustible items from gas, fuel-oil, or solid-fuel-burning heaters or furnaces.

(d) When in use, fireplaces, wood-burning stoves, solid-fuel-burning appliances, space heaters, steam radiators, outdoor fire pits, and other potentially hot surfaces, such as steam pipes, must be protected by guards or protective covering to keep hands and bodies away, prevent burns, and prevent fires. All fireplaces, wood-burning stoves, space heaters, steam radiators, and furnaces must be installed according to the State Building Code. The furnace, hot water heater, and utility rooms must be inaccessible to children.

(e) Ventilation of usable space must meet the requirements of the State Building Code. Outside doors and windows used for ventilation in summer months must be screened when biting insects are prevalent. The screens must be in good repair. Sources of harmful and unpleasant odors including urine and pet waste must be removed to the extent possible by removing the source of the odor or by removing odors through cleaning and ventilation.

Subd. 11. **Temperature.** A minimum temperature of 62 degrees Fahrenheit must be maintained in indoor areas used by children.

Subd. 12. **Sewage disposal.** Family child care programs must have working toilets and a sewage disposal system that conform to the State Building Code or local septic system ordinances. Toilet training equipment must be emptied and cleaned after each use. Outdoor toilets, including compostable toilets, are permissible in accordance with local septic system ordinances.

Subd. 13. **Construction or remodeling.** During construction or remodeling, children must not have access to construction or remodeling areas within or around the premises.

Subd. 14. **Interior walls and ceilings.** The walls and ceilings within a family child care program, including those in corridors, stairways, and lobbies, must have a flame spread rating of 200 or less.

Subd. 15. **Electrical services.** (a) All electric outlets in a family child care program accessible to children must be tamper-proof or shielded when not in use. All major electrical

appliances must be properly installed and grounded in accordance with the State Electrical Code and in good working order.

(b) Electrical wiring must be sized to provide for the load and be in good repair. Extension cords must not be used as a substitute for permanent wiring.

Subd. 16. **Fire extinguisher.** A portable, operational, multipurpose, and dry chemical fire extinguisher with a minimum 2-A 10-BC rating must be located near the required exit door of the program at all times. The fire extinguisher must be serviced annually by a qualified inspector and evidence of annual service must be documented. All caregivers must know how to properly use the fire extinguisher.

Subd. 17. **Carbon monoxide and smoke alarms.** (a) A family child care program must have an approved and operational carbon monoxide alarm installed within ten feet of each area used for sleeping children in care.

(b) A family child care program must properly install and maintain smoke alarms models that have been approved by the Underwriter Laboratory on all levels, including basements, and in hallways outside rooms used for sleeping children in care. Smoke alarms are not required in crawl spaces and uninhabitable attics. For family child care programs in buildings that began construction on or after March 31, 2020, smoke alarms must be installed and maintained in each room used for children in care to sleep.

Subd. 18. **Stairways.** All family child care programs with stairways must:

(1) have handrails on at least one side of stairways of four or more steps;

(2) enclose any open area between the handrail and stair tread with a protective guardrail as specified in the State Building Code. The back of the stair risers must also be enclosed;

(3) use gates at the top and bottom of stairways when children who are six to 18 months old are in care; and

(4) keep stairways well lit, in good repair, and free of clutter and obstructions.

Subd. 19. **Lofted spaces.** Decks, balconies, or lofts that are used by children and are more than 30 inches above the ground or floor must be surrounded by a protective guardrail and be constructed in compliance with the State Building Code. The State Building Code allows appropriate openings for access to the spaces under this subdivision, such as a doorway or a gate. Wooden decks must be free of splinters and in good repair.

Subd. 20. **Locks and latches.** (a) A door latch on a closet or other confining space must be able to be unlatched so that the door can be opened from inside the closet or other confining space.

(b) Every interior door lock must permit opening of the locked door from the outside and the opening device must be readily accessible to all caregivers.

(c) Exit doors must not have double cylinder locks where a key is required on both sides.

(d) Locks may not be used in place of supervision.

Subd. 21. **Tobacco products, cannabis, vaping, drugs, and alcohol use prohibitions.** (a) Smoking of tobacco, cannabis, or any other product, including through electronic delivery devices, is prohibited in both indoor and outdoor family child care program environments and in any vehicles used by the family child care program during hours of operation.

(b) The use of alcohol or illegal or recreational drugs is prohibited on the premises of a family child care program during hours of operation.

(c) If the license holder allows smoking of tobacco, cannabis, or any other product, including through electronic delivery devices, on the premises outside of child care hours, the license holder must verbally provide notice to parents and must post written notice in an obvious location disclosing this information.

(d) While caring for children, a caregiver must not be under the influence of any substance that impairs the individual's ability to supervise children or perform the individual's duties.

Sec. 15. **[142I.15] CLEANING AND DISINFECTING.**

Subdivision 1. **General requirements.** (a) The family child care program must be free from accumulations of dirt, peeling paint, visible or known debris, soiled items, hazardous clutter, and pet waste.

(b) Disinfectants must:

(1) not be used prior to or in place of cleaning compounds;

(2) be mixed and used according to the manufacturer's instructions; and

(3) be used on surfaces that are contaminated with bodily fluids.

Subd. 2. **Toys.** A caregiver must clean and disinfect a toy that has been in a child's mouth prior to use by another child. Toys that come into contact with bodily fluids must be cleaned

and disinfected prior to next use. Toys must be cleaned and disinfected as needed if there are visible or known contaminants or debris on them.

Subd. 3. **Food and eating areas.** Surfaces and tools that are used for preparing or serving food must be cleaned.

Subd. 4. **Indoor and outdoor equipment.** The indoor and outdoor space and equipment of the family child care program must be clean.

Subd. 5. **Sleeping.** Bedding, as defined in section 142I.17, subdivision 10, must be cleaned and disinfected at least weekly or when visibly dirty.

Subd. 6. **Toilet training equipment.** Toilet training chairs and seats must be cleaned and disinfected after each use.

Subd. 7. **Hand washing.** (a) A child's hands must be washed with soap and running water when soiled, after the use of a toilet or toilet training chair, and before eating a meal or snack. The caregiver must monitor and assist a child who needs help. Children's hands must be dried on a separate or single-use towel.

(b) In sinks and tubs accessible to children, the water temperature must not be able to exceed 120 degrees Fahrenheit.

(c) Caregivers must wash their hands with soap and water after each diaper change, after assisting a child on the toilet, after washing the diapering surface, and before food preparation. The caregiver's hands must be dried on a separate or single-use towel.

Subd. 8. **Diapers, changing areas, and disposal.** (a) An adequate supply of clean diapers must be available for each child who uses diapers. Diapers may be disposable or made of cloth. Diapers must be stored in a clean space that is inaccessible to children.

(b) If a family child care program uses cloth diapers, then:

(1) the cloth diapers must have an absorbent inner layer that is completely covered with an outer waterproof layer that has a waist closure;

(2) the cloth diaper and waterproof layer must be changed at the same time; and

(3) the cloth diapers supplied by parents, except those supplied by a commercial diaper service, must be labeled with the child's name and must be placed in a plastic bag after removal with any soiled clothing and sent home with the parent daily.

(c) Single-service disposable wipes or clean washcloths must be used for washing a soiled child before rediapering.

(d) The diaper changing area must be covered with a smooth, nonabsorbent surface. Changing tables, changing pads, and other diaper changing areas must be cleaned and disinfected between children, even if using a nonabsorbent covering that is discarded after each use. Diapering must not take place in a food preparation area.

(e) Disposable diapers must be disposed of in a covered container located in the diaper changing area and lined with a disposable plastic bag or directly outdoors in a garbage can.

Sec. 16. **[142I.16] ENVIRONMENTAL HEALTH.**

Subdivision 1. **Water supply.** (a) All family child care programs must have a safe water supply.

(b) Family child care programs that draw water from privately owned wells must test the water annually by a Department of Health-certified laboratory for coliform bacteria and nitrate nitrogen and receive confirmation that the water is safe. The family child care program must submit a copy of the test results with the agency. Retesting and corrective measures may be required by the agency if results do not meet state drinking water standards or where the supply may be subject to off-site contamination. A copy of the most recent water testing results must be kept on the licensed premises. If the water test results are at or above Department of Health-recommended levels or if the license holder declines to test the water supply in the program, the license holder must:

(1) supply bottled or packaged water;

(2) use water filtration devices that have been certified by the National Science Foundation or American National Standards Institute to remove the contaminant. The water filtration device must be attached directly to water faucets, inserted into the refrigerator water dispenser, or inserted into water pitchers or bottles. The water filtration device must be maintained according to manufacturer guidelines; or

(3) close the family child care program to prevent children from using or consuming unsafe water.

Subd. 2. **Radon testing.** (a) The license holder must notify parents whether radon testing has been conducted in the family child care program upon enrollment and within 30 days of any subsequent testing done after enrollment.

(b) When notifying parents, the license holder must use a form prescribed by the commissioner. The notice must include information from the Department of Health about what radon is and the potential risks associated with radon exposure. If testing has been completed, the notice must include:

(1) the date of the most recent test;

(2) the rooms or areas tested; and

(3) the detected radon level or levels, stated in picocuries per liter (pCi/L).

(c) A copy of the most recent notice to parents and the radon test results must be kept on site and made available to parents and the commissioner upon request.

(d) The notification requirements under this subdivision may be met by posting the form in a prominent place.

Sec. 17. **[142I.17] ACTIVITIES AND EQUIPMENT.**

Subdivision 1. **General activities.** Child care activities must provide for the physical, intellectual, emotional, and social development of the children in care at a family child care program. Activities must include infants, toddlers, preschoolers, and school-age children and:

(1) be scheduled indoors and outdoors daily, weather permitting. When determining if the weather permits outdoor play, a license holder must defer to weather advisory notifications, including air quality emergencies, provided by local weather experts, local or state authority on air quality, or public health;

(2) be appropriate to the age and developmental stage of the child;

(3) include active and quiet activity; and

(4) include both caregiver- and child-directed activities.

Subd. 2. **Equipment.** (a) A license holder must provide children in a family child care program with:

(1) sufficient play equipment to allow each child a choice of at least three activities involving equipment when all children are using equipment;

(2) early learning materials, play equipment, and space that are age and developmentally appropriate and support understanding of the culturally diverse world; and

(3) play equipment that is safe, in good repair, and used in accordance with the manufacturer's instructions, if applicable.

(b) Equipment provided to children under this section may be new, used, commercially made, or homemade. The equipment must be appropriate for the ages of the children and for the activities for which it will be used. As appropriate, nature material may be used in place of any equipment.

Subd. 3. **Newborn or infant activities.** A caregiver must:

(1) hold a newborn or infant during feedings until the child can hold the bottle. A bottle cannot be propped up for a newborn or infant;

(2) respond to a newborn's or infant's attempts to communicate;

(3) develop infant language and communication by responding to a newborn's or infant's attempts to communicate by mirroring similar sounds, sharing the child's focus of attention, talking to the newborn or infant, naming objects, and describing actions;

(4) provide a newborn or infant with freedom of movement to sit safely and comfortably, crawl, toddle, walk, and play both indoors and outdoors throughout the day;

(5) provide a newborn or infant an opportunity to stimulate the senses by providing a variety of activities and objects to see, touch, feel, smell, hear, and taste;

(6) provide activities for a newborn or infant that develop the child's manipulative and fine motor skills;

(7) provide activities for self-awareness;

(8) provide activities to support a newborn or infant to develop social-emotional skills;

(9) provide activities to support a newborn or infant to develop gross motor skills; and

(10) allow a newborn or infant actively supervised tummy time. For the purposes of this clause, "tummy time" means placing a newborn or infant in a nonrestrictive prone position, lying on their stomach. Tummy time should occur throughout the day when a newborn or infant is awake. A newborn or infant must not be wearing anything to restrict movement during tummy time.

Subd. 4. **Newborn and infant equipment.** When caring for newborns or infants, a license holder must provide:

(1) an infant seat or high chair, as appropriate, for each newborn and infant in attendance;

(2) a crib or portable crib with a mattress or pad for each newborn and infant in attendance that is in compliance with current Consumer Product Safety Commission safety standards and chapter 142B.45. The license holder must maintain documentation on site that the equipment used meets these requirements and provide it to the commissioner and parents as requested;

(3) books and literacy materials;

(4) gross motor activity equipment; and

(5) fine motor activity materials.

Subd. 5. **Toddler activities.** When caring for toddlers, a license holder must:

(1) provide the toddler with freedom of movement and freedom to explore outside the crib or portable crib and allow the toddler to comfortably sit, crawl, toddle, walk, and play according to the toddler's stage of development;

(2) talk to, listen to, and interact with the toddler to encourage language development;

(3) provide the toddler with activities that develop the toddler's fine and gross motor skills;

(4) give the toddler opportunities to stimulate the senses by providing a variety of age-appropriate activities and objects to see, touch, feel, smell, hear, and taste; and

(5) provide activities to support the toddler to develop social-emotional skills.

Subd. 6. **Toddler equipment.** When caring for toddlers, a license holder must provide:

(1) separate sleeping equipment for each toddler such as a mat, crib, cot, bed, sofa, or sleeping bag that is cleaned and maintained as required in subdivision 10 and section 142I.15, subdivision 5;

(2) gross motor play equipment;

(3) books and literacy materials;

(4) fine motor, math, and science materials; and

(5) music, movement, and art activity materials.

Subd. 7. **Preschooler activities.** When caring for preschoolers, a license holder must:

(1) encourage conversation between the preschooler and other children and adults;

(2) provide opportunity to play near and with other children, provide time and space for individual and group play, allow for quiet times to talk or rest, and allow for unplanned time and individual play time;

(3) foster understanding of personal and peer feelings and actions and allow for the constructive release of a range of feelings through discussion or play;

(4) give assistance in toileting and provide time to carry out self-help skills and provide opportunities to be responsible for activities;

(5) provide opportunities for each preschooler to make decisions about daily activities and to learn from the decision-making experiences;

(6) provide time and areas for age-appropriate gross motor play;

(7) provide learning, fine-motor, manipulative, creative, or sensory activities; and

(8) read stories, look at books, and talk about new words and ideas with the preschooler.

Subd. 8. **Preschooler equipment.** When caring for preschoolers, a license holder must provide:

(1) separate sleeping equipment for each preschooler such as a mat, bed, cot, sofa, or sleeping bag for each preschooler that is cleaned and maintained as required under subdivision 10 and section 142I.15, subdivision 5;

(2) dramatic play equipment;

(3) books and literacy materials;

(4) fine motor materials;

(5) gross motor play equipment;

(6) math materials;

(7) science materials;

(8) music and movement materials; and

(9) art materials.

Subd. 9. **School-age activities and equipment.** When caring for school-age children, a license holder must:

(1) provide opportunities for individual discussion about the day and planning for activities;

(2) provide space, opportunities, and materials or equipment for games, activities, or sports using the whole body;

(3) have available space, bedding materials, and opportunities for individual rest and quiet time required under subdivision 10;

(4) allow increased freedom as the school-age child demonstrates increased responsibility;

(5) provide opportunities for group experiences with other children;

(6) provide opportunities to develop or expand self-help skills or real-life experiences; and

(7) provide opportunities and materials for creative and dramatic activity, arts, and crafts.

Subd. 10. **Bedding.** Clean, separate, and individual bedding such as sheets, towels, blankets, or sleeping bags must be available for each child in care. For children not using cribs or portable cribs, the license holder must provide developmentally appropriate mats, cots, or other sleep equipment that can be cleaned and disinfected according to section 142I.15. Mats, cots, and other sleep equipment used in the family child care program must be in good condition and have no tears or holes and be covered in individual bedding.

Subd. 11. **Separation of personal articles.** Separate towels, wash cloths, water bottles, and drinking cups must be used for each child and labeled appropriately.

Sec. 18. **[142I.18] INFANT SLEEP AND CRIB REQUIREMENTS.**

Subdivision 1. **Safety.** All caregivers must follow the crib safety requirements in section 142B.45 and the requirements to reduce the risk of sudden unexpected infant deaths in section 142B.46. During routine licensing inspections and when investigating complaints regarding alleged violations of this section, the commissioner must review the license holder's documentation required under section 142B.45.

Subd. 2. **Monitoring sleeping newborns and infants.** (a) Caregivers must directly supervise newborns once they are placed in a crib or portable crib.

(b) License holders of programs that serve infants are encouraged to monitor sleeping infants by conducting in-person checks on each infant in the license holder's care every 30 minutes.

(c) Upon enrollment of an infant, the license holder is encouraged to conduct in-person checks on the sleeping infant every 15 minutes during the first four months of care.

(d) When an infant has an upper respiratory infection, the license holder is encouraged to conduct in-person checks on the sleeping infant every 15 minutes throughout the hours of sleep.

(e) Monitors may be used to supervise infants when the infants are sleeping. However, the use of monitors does not replace the in-person checks encouraged under paragraphs (b) to (d). When in use, monitors must meet the following conditions:

(1) the sound monitoring equipment must be able to pick up the sounds of all infants in the separate room;

(2) the receiver of the sound monitoring equipment must be actively monitored by the adult caregiver at all times; and

(3) sound monitoring equipment must be checked daily prior to use to ensure it is working correctly. If the sound equipment is not functioning, infants must sleep in the same room as the adult caregiver.

(f) If music or other sounds are played in the infant sleep area, the music or other sound equipment must not be played at a volume that would prevent infants from being heard by the adult caregiver. This paragraph applies to fans used to create sound.

Sec. 19. **[142I.19] HEALTH POLICIES AND SAFETY REQUIREMENTS.**

Subdivision 1. **Handling and disposal of bodily fluids.** (a) Surfaces that come in contact with bodily fluids must be cleaned and disinfected as described in section 142I.15.

(b) Blood-contaminated material must be disposed of in a plastic bag and securely tied.

(c) If a program cares for a child with a health care need that requires injectable medication, the program must have a sharps container available.

(d) A license holder must keep disposable gloves, disposal bags, and eye protection available. Prescription eyewear does not meet the requirements of this paragraph.

Subd. 2. **Emergencies.** (a) A license holder must have a written child care emergency plan for emergencies that require evacuation, sheltering, or other protection of children, including for fires, natural disasters, intruders, or other threatening situations that may pose a health or safety hazard to children. The plan must be written on a form prescribed by the commissioner and updated at least annually. The plan must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent of an evacuation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitate easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis;

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities; and

(8) accommodations for infants and toddlers.

(b) The license holder must train each caregiver on the child care emergency plan before the caregiver provides care and document this training. The information must be reviewed at least annually and updated when information changes.

(c) The child care emergency plan must be available for review by the agency during inspections.

(d) In addition to the emergency plan required under paragraph (a), the license holder must maintain preparedness for emergencies. An operable telephone must be located in the family child care program. A cellular telephone may be used if it is sufficiently charged for use at all times. Emergency phone numbers for parents must be readily available within the program and taken on all emergency drills and evacuations.

(e) For severe storms and tornadoes, the license holder must have a designated area that children can go to for shelter, a battery-operated flashlight, and a portable radio or TV available. An application on a smartphone may be used to meet the requirements of this paragraph. The license holder must follow guidance and instructions from the Emergency Alert System or local alerting systems.

(f) The license holder must have a written fire escape plan that includes:

(1) the address of the family child care program;

(2) emergency phone numbers;

(3) a designated place to meet and confirm that all children in attendance are present;

(4) fire extinguisher locations;

(5) plans for monthly fire and storm drills; and

(6) escape routes to the outside from all levels used by children. In buildings with three or more dwelling units, enclosed exit stairs must be indicated.

(g) The license holder must complete a monthly fire and storm drill and have documentation of completed fire drills available for review by the agency during inspections. The log must include the date of the drill, the time of day the drill occurred, the name of the caregiver who conducted the drill, and the length of time taken to evacuate all children safely.

Subd. 3. **Transporting children.** Children must only be transported in an enclosed passenger vehicle capable of using car seats or a bus operated by a common carrier. When transporting children in an enclosed passenger vehicle other than a bus operated by a common carrier, a license holder must:

(1) ensure compliance with all seat belt and child passenger restraint system requirements under sections 169.685 and 169.686;

(2) ensure that the child is fastened in a safety seat, seat belt, or harness appropriate to the age and weight of the child and the restraint is installed and used in accordance with the manufacturer's instructions;

(3) only use a vehicle licensed in accordance with the laws of the state and driven by a caregiver with a current, valid driver's license. A copy of the current driver's license for each caregiver who transports a child in care must be kept at the family child care program;

(4) receive written permission to transport children from parents prior to transport; and

(5) not allow a child to remain unattended in any vehicle.

Subd. 4. **Pets and animals.** When keeping pets or animals on the site of a family child care program or allowing children to have contact with pets or animals, the primary provider of care must:

(1) maintain the pets or animals in good health and proper housing. Pets or animals must be appropriately immunized, and rabies vaccinations must be documented with a current certificate from a veterinarian when appropriate;

(2) follow all local and state ordinances regarding the keeping, licensing, number, and health status of animals;

(3) restrict any animals that pose a risk of injury or illness to children from indoor and outdoor areas used by children;

(4) inform parents in writing of the presence of pets and animals on the premises. If pets or animals are allowed to roam in areas occupied by children, the license holder must obtain written acknowledgment from parents. Parents must be notified in writing prior to the introduction of a new pet;

(5) keep any reptiles, amphibians, ferrets, poisonous animals, psittacine birds, exotic animals, and wild animals inaccessible to children. Licensed animal exhibitions, such as mobile petting zoos, reptile shows, and educational presentations are exempt from this clause with written parental notice and consent;

(6) not allow any contact between children and pets or animals that is not directly supervised by an adult caregiver who is in close physical proximity and able to immediately intervene if the child or animal shows distress or aggression or if the child is treating the animal inappropriately;

(7) immediately intervene to protect a child when necessary;

(8) prevent pets and animals from accessing food preparation, storage, and serving areas when food is being prepared or served, unless confined in a cage or kennel. Litter boxes are prohibited in any food preparation, storage, or serving areas;

(9) keep indoor and outdoor areas accessible to children free of animal waste, including litter boxes and their contents. Pet cages, enclosures, and aquariums accessible to children must be located and cleaned away from food areas;

(10) immediately notify a parent of a child who receives an animal bite or scratch;

(11) notify the local animal authority whenever an individual is bitten by an animal on the day of injury. The notification must be made before any steps are taken to euthanize the animal, and the license holder must take reasonable steps to confine the animal; and

(12) notify the licensing agency within 24 hours of any animal bite from an animal housed at the family child care program.

Subd. 5. **Pest control.** (a) A license holder must take effective measures to protect the family child care program against pests. The license holder must take steps to prevent attracting pests and, if pests are present inside the family child care program, to remove or exterminate the pests.

(b) Chemicals for pest control must not be applied in areas accessible to children when children are present. The license holder must use chemicals according to manufacturer instructions. Only approved, Environmental Protection Agency-registered insecticides, rodenticides, and herbicides may be used. Application must strictly follow all label instructions.

Subd. 6. **Garbage.** Garbage must be inaccessible to infants and toddlers. Garbage is considered inaccessible when the garbage container has a lid on.

Subd. 7. **Firearms.** (a) All caregivers, parents, household members, and visitors to a family child care program must comply with the requirements of this subdivision during program hours.

(b) Ammunition and firearms must be stored in locked areas separated from areas accessible to children. Firearms must be unloaded while stored.

(c) License holders must notify parents upon admission of the presence of firearms. If a firearm is added to the property, a license holder must notify parents by the end of the following business day.

(d) Loaded and unloaded firearms may be carried by a law enforcement official who is a household member or a parent of a child in care and can document that their jurisdiction requires ready and immediate access to the firearm.

Subd. 8. **First aid kit.** A license holder must have a first aid kit that is accessible to caregivers in the family child care program at all times and taken on field trips. A caregiver must have access to first aid instructions. The first aid kit must contain:

(1) adhesive bandages in assorted sizes and tape;

(2) sterile compresses;

(3) scissors;

(4) an ice bag or cold pack;

(5) a thermometer;

(6) mild liquid soap, hand sanitizer, or alcohol wipes; and

(7) disposable powder-free, latex-free gloves.

Subd. 9. **Care of sick children.** (a) If the child becomes sick while at the family child care program, the child must be separated from other children in care to the extent possible while still maintaining appropriate supervision, and the child's parent must be called immediately. When determining if a child is sick and exclusion is necessary, a license holder must follow:

(1) the requirements on reportable diseases in Minnesota Rules, parts 4605.7040, 4605.7070, and 4605.7080; and

(2) the guidelines from the commissioner of health on infectious diseases in child care settings.

(b) When notified a child in care is sick with a reportable disease under Minnesota Rules, part 4605.7040, 4605.7050, or 4605.7080, the license holder must:

(1) follow the family child care program policies on reportable or infectious diseases; and

(2) notify the commissioner of health within 24 hours of receiving the parent or staff report. Documentation of the notification must be kept at the family child care program.

(c) Children with a reportable disease in paragraph (b) must be excluded from the family child care program for the length of time specified in the commissioner of health guidelines on infectious diseases in child care settings, until the child can participate in routine activities

without more caregiver supervision than usual or until the child's health care provider determines that exclusion is no longer necessary, whichever is longer.

Subd. 10. **Medication administration requirements.** (a) A license holder must obtain written permission from the parent of a child prior to administering nonprescription medicine, diapering products, sunscreen lotions, and insect repellents. These items must be administered according to the manufacturer instructions unless written instructions for their use are provided by a health care provider.

(b) A license holder must obtain and follow written instructions from a health care provider or dentist prior to administering each prescribed medication. For the purposes of this paragraph, "instructions" means the label on a medicine container with the child's name and current prescription information.

Sec. 20. **[142I.20] FOOD AND NUTRITION.**

Subdivision 1. **Feeding.** (a) Bottles of frozen breast milk or formula must be thawed under warm running water, in a container of warm water, with a warming device, or in a refrigerator. Thawed milk must be used, sent home, or disposed of the same day it is thawed.

(b) Caregivers must not warm plastic bottles, sippy cups, or other plastic food containers in a microwave.

(c) Once bottle feeding is complete, any unused portion must be disposed of or stored inaccessible to children in care. Bottles provided by or stored at the family child care program must be washed prior to the next use.

(d) Caregivers must not serve food to infants or toddlers using polystyrene foam (Styrofoam) cups, bowls, or plates.

Subd. 2. **Milk.** Cow's milk served to children in care must be pasteurized. Milk alternatives that are nutritionally equivalent to cow's milk can be served in place of milk for children who require it.

Subd. 3. **Drinking water.** Drinking water from a safe source according to section 142I.16 must be readily available and offered to the children throughout the day in indoor and outdoor areas.

Subd. 4. **Meals and snacks.** (a) Well-balanced meals and snacks must be supplied by the license holder or parents daily. Every meal and snack served to children in care must meet the following requirements:

(1) breakfast must contain at least three of the following:

(i) pasteurized milk or milk alternatives;

(ii) vegetables;

(iii) fruit; or

(iv) grains;

(2) lunch and dinner must contain at least four of the following:

(i) pasteurized milk or milk alternatives;

(ii) meat or meat alternatives;

(iii) vegetables;

(iv) fruit; or

(v) grains; and

(3) snacks must contain at least two of the following:

(i) pasteurized milk or milk alternatives;

(ii) meat or meat alternatives;

(iii) vegetables;

(iv) fruit; or

(v) grains.

(b) Food, liquids, and bottles brought from home must be labeled with the first and last name of each child.

(c) Flexible feeding schedules must be provided for infants.

(d) When special diets are required for cultural, religious, or medical reasons, the provider must obtain written, dated, and signed instructions from the child's parent.

Subd. 5. **Food and liquid safety.** (a) Food and liquids must be handled and stored properly to prevent contamination and spoilage. Foods and liquids requiring refrigeration must be refrigerated and maintained at no more than 40 degrees Fahrenheit. Food requiring heating must be maintained at no less than 140 degrees Fahrenheit until ready to serve. Frozen foods must be kept frozen until use and cooked according to the manufacturer's instructions.

(b) Appliances used in food and liquid storage and preparation must be safe and clean.

(c) All canned food provided by the license holder must be commercially processed. Locally grown fresh and frozen fruits and vegetables may be served at the family child care program. Food canned or preserved at home and home-butchered meats, poultry, and fish may not be served to children in care.

Sec. 21. **[142I.21] CHILDREN WITH SPECIAL HEALTH CARE NEEDS OR DISABILITIES.**

(a) For children with disabilities who require therapy, additional behavior guidance, programming, or alternative accommodations, a parent or health care provider must provide written instructions for the license holder to follow.

(b) All activities must be designed to include all children unless a specific medical contraindication exists.

(c) All caregivers responsible for the care of a child with a disability or special health care need must explain to a parent and the agency how the child's specific needs are being met.

(d) Before enrolling a child for care, the license holder must obtain documentation of any known allergies on a form prescribed by the commissioner. The form must be readily available to all caregivers and reviewed by the license holder and each caregiver annually and when any updates or changes are made.

(e) If a child has a known allergy, the primary provider of care must maintain current information about the allergy in the child's record, ensure that required medication is on hand, and follow the allergy plan signed by a treating medical professional. The child's plan must include:

(1) a description of the allergy;

(2) specific triggers and avoidance techniques;

(3) symptoms of an allergic reaction; and

(4) procedures for responding to an allergic reaction, including any medication and dosage to be administered in an emergency situation.

(f) A caregiver must call emergency medical services when epinephrine is administered to a child in the license holder's care.

(g) The caregiver must contact the child's parent immediately after any instance of exposure to an allergen or allergic reaction.

Sec. 22. **[142I.22] COMMUNITY-BASED FAMILY CHILD CARE.**

(a) A family child care program located on a site other than the license holder's primary residence must be licensed under this section if:

(1) the family child care program is conducted in a dwelling on a residential lot or in a commercial space other than the license holder's primary residence;

(2) the license holder is an organization, employer, church, or religious entity; or

(3) the license holder is a community collaborative child care provider. For purposes of this clause, a "community collaborative child care provider" is a provider participating in a cooperative agreement with a community action agency as defined in section 142F.301.

(b) Programs licensed under paragraph (a) must comply with local zoning regulations, the applicable State Fire Code, and the State Building Code. Any age and capacity limitations established by the fire code must be printed on the license.

(c) A license holder under this section must designate at least one primary provider of care as follows:

(1) one individual for programs operating eight or fewer hours per day;

(2) up to two individuals for programs operating more than eight but no more than 16 hours per day; and

(3) up to three individuals for programs operating more than 16 hours per day.

(d) The license issued under this section must include the statement: "This community-based family child care license holder is not licensed as a child care center."

(e) The commissioner may approve up to four licenses at the same location or under one contiguous roof if each license holder independently meets all applicable requirements. Each family child care program must operate as a distinct family child care program within its licensed capacity, age, and ratio limits as determined by the state fire marshal. Only one license may be issued per single-family residential home.

(f) The license holder must notify the commissioner in writing before any change in the persons designated as primary providers of care. A primary provider of care is authorized to communicate with the commissioner on licensing matters.

(g) Each license holder must complete the commissioner-developed community-based family child care program plan at the time of initial application, review the plan each calendar year, and update the plan before any change in program information occurs.

Sec. 23. **REVISOR INSTRUCTION.**

(a) The revisor of statutes must make any necessary changes to statutory cross-references to reflect the changes in this article.

(b) The revisor of statutes must replicate the statutory history for all sections and subdivisions repealed and reenacted in this article.

Sec. 24. **REPEALER.**

(a) Minnesota Statutes 2024, sections 142B.01, subdivision 13; 142B.41, subdivisions 4 and 8; 142B.62; 142B.70, subdivisions 1, 2, 3, 4, 5, 6, 9, 10, 11, and 12; 142B.71; 142B.72; 142B.74; 142B.75; 142B.76; and 142B.77, are repealed.

(b) Minnesota Statutes 2025 Supplement, sections 142B.41, subdivision 9; and 142B.70, subdivisions 7 and 8, are repealed.

(c) Minnesota Rules, parts 9502.0300; 9502.0315; 9502.0325; 9502.0335; 9502.0341; 9502.0345; 9502.0355; 9502.0365; 9502.0367; 9502.0375; 9502.0395; 9502.0405; 9502.0415; 9502.0425; 9502.0435; and 9502.0445, are repealed.

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

ARTICLE 8

MINNESOTA AFRICAN AMERICAN FAMILY PRESERVATION AND CHILD WELFARE DISPROPORTIONALITY ACT

Section 1. Minnesota Statutes 2024, section 260.63, subdivision 10, is amended to read:

Subd. 10. **Disproportionately represented child.** "Disproportionately represented child" means a person who is under the age of 18 and who is a member of a community whose race, ~~culture,~~ ethnicity, disability status, or low-income socioeconomic status is disproportionately encountered, engaged, or identified in the child welfare system as compared to the representation in the state's total child population, as determined ~~on an annual basis~~ by the commissioner under section 260.631. A child's race~~, culture,~~ or ethnicity ~~is~~ may also be determined ~~based upon~~ by a child's self-identification or identification of a child's race, culture, or ethnicity as reported by the child's parent or guardian.

Sec. 2. **[260.631] DETERMINATIONS.**

Subdivision 1. **Determination of disproportionate representation.** (a) The commissioner must determine the communities that are disproportionately represented in Minnesota's child protection system pursuant to this section for the purposes of the Minnesota

African American Family Preservation and Child Welfare Disproportionality Act. In making this determination, the commissioner must consider the recommendations provided under paragraph (d). The commissioner's determination under this paragraph is in effect until the effective date of the next determination issued by the commissioner.

(b) The commissioner must make the initial determination under paragraph (a) by September 1, 2026, and then every even-numbered year thereafter.

(c) A responsible social services agency must use the commissioner's determination under paragraph (a) to determine whether a child meets the definition of a disproportionately represented child under section 260.63, subdivision 10.

(d) The African American Child and Family Well-Being Advisory Council must submit recommendations to the commissioner on the disproportionate representation of African American children in Minnesota's child protection system, using state and federal census data. The council must provide its initial recommendations to the commissioner by August 1, 2026, and then provide recommendations every even-numbered year thereafter.

(e) If the commissioner makes a determination under paragraph (a) that differs from the recommendations provided by the African American Child and Family Well-Being Advisory Council under paragraph (d) regarding the disproportionate representation of African American children in Minnesota's child protection system, the commissioner must provide the reasons for diverging from the council's recommendations and identify the data the commissioner relied upon in making the determination of disproportionate representation. The commissioner must provide the information required under this paragraph to:

(1) the chairs and ranking minority members of the legislative committees with jurisdiction over the Minnesota African American Family Preservation and Child Welfare Disproportionality Act;

(2) the African American Child and Family Well-Being Advisory Council;

(3) the Children's Justice Initiative; and

(4) responsible social services agencies statewide.

(f) By September 15, 2026, and every even-numbered year thereafter, the commissioner must notify responsible social services agencies, the council, and the Children's Justice Initiative of the commissioner's determination under paragraph (a). The notification must include, but is not limited to:

(1) a list of the communities the commissioner determined are disproportionately represented in Minnesota's child protection system, and whether there are any changes from the previous notification;

(2) how a responsible social services agency must implement the commissioner's determination;

(3) the effective date of the commissioner's determination; and

(4) the method or methods the commissioner used, or the data the commissioner relied upon, to make the determination.

Subd. 2. **Definition of disability; low-income socioeconomic status.** (a) The commissioner must define what constitutes disability and low-income socioeconomic status for purposes of the Minnesota African American Family Preservation and Child Welfare Disproportionality Act. The commissioner's definitions under this paragraph are in effect until the effective date of the next definitions issued by the commissioner.

(b) The commissioner must develop the initial definitions under paragraph (a) by September 1, 2026, and then every even-numbered year thereafter.

(c) A responsible social services agency must use the commissioner's definitions under paragraph (a) to determine whether a child meets the definition of a disproportionately represented child under section 260.63, subdivision 10.

(d) By September 15, 2026, and every even-numbered year thereafter, the commissioner must notify responsible social services agencies, the council, and the Children's Justice Initiative of the definitions developed by the commissioner under paragraph (a). The notification must include, but is not limited to:

(1) the definitions of disability and low-income socioeconomic status, and whether there are any changes from the previous definitions;

(2) how a responsible social services agency must implement the commissioner's definitions;

(3) the effective date of the commissioner's definitions; and

(4) the method or methods the commissioner used, or the data the commissioner relied upon, to develop the definitions.

Subd. 3. **Determination of child's status.** The responsible social services agency must document the efforts the agency takes when determining whether a child meets or does not

meet the definition of disproportionately represented child under section 260.63, subdivision 10, and must provide that information to the commissioner upon request.

Sec. 3. Minnesota Statutes 2024, section 260.64, subdivision 2, is amended to read:

Subd. 2. **Safety plan.** (a) Prior to petitioning the court to remove an African American or a disproportionately represented child from the child's home under section 260.66, a responsible social services agency must work with the child's family to allow the child to remain in the child's home while implementing a safety plan based on the family's needs. The responsible social services agency must:

(1) make active efforts to engage the child's parent or custodian and the child, when appropriate;

(2) assess the family's cultural and economic needs and, if applicable, needs and services related to the child's disability;

(3) hold a family group consultation meeting and connect the family with supports to establish a safety network for the family; and

(4) provide support, guidance, and input to assist the family and the family's safety network with developing the safety plan.

(b) The safety plan must:

(1) address the specific allegations impacting the child's safety in the home. If neglect, as defined in section 260E.03, subdivision 15, is alleged, the safety plan must incorporate economic services and supports for the child and the child's family, if eligible, to address the family's specific needs and prevent neglect;

(2) incorporate family and community support to ensure the child's safety while keeping the family intact; and

(3) be adjusted as needed to address the child's and family's ongoing needs and support.

(c) The responsible social services agency is not required to establish a safety plan:

(1) in a case with allegations of sexual abuse or egregious harm;

(2) when the parent is not willing to follow a safety plan;

(3) when the parent has abandoned the child or is unavailable to follow a safety plan; or

(4) when the parent has chronic substance use disorder issues and is unable to parent the child.

Sec. 4. Minnesota Statutes 2024, section 260.67, subdivision 2, is amended to read:

Subd. 2. **Termination of parental rights restrictions.** (a) A court shall not terminate the parental rights of a parent of an African American or a disproportionately represented child based solely on the parent's failure to complete case plan requirements.

(b) Except as provided in ~~paragraph (c)~~ subdivision 3, a court shall not terminate the parental rights of a parent of an African American or a disproportionately represented child in a child placement proceeding unless the allegations against the parent involve sexual abuse; egregious harm as defined in section 260C.007, subdivision 14; murder in the first, second, or third degree under section 609.185, 609.19, or 609.195; murder of an unborn child in the first, second, or third degree under section 609.2661, 609.2662, or 609.2663; manslaughter of an unborn child in the first or second degree under section 609.2664 or 609.2665; domestic assault by strangulation under section 609.2247; felony domestic assault under section 609.2242 or 609.2243; kidnapping under section 609.25; solicitation, inducement, and promotion of prostitution under section 609.322, subdivision 1, and subdivision 1a if one or more aggravating factors are present; criminal sexual conduct under sections 609.342 to 609.3451; engaging in, hiring, or agreeing to hire a minor to engage in prostitution under section 609.324, subdivision 1; solicitation of children to engage in sexual conduct under section 609.352; possession of pornographic work involving minors under section 617.247; malicious punishment or neglect or endangerment of a child under section 609.377 or 609.378; use of a minor in sexual performance under section 617.246; or failing to protect a child from an overt act or condition that constitutes egregious harm.

Sec. 5. Minnesota Statutes 2024, section 260.68, subdivision 2, is amended to read:

Subd. 2. **Case review.** (a) ~~Each responsible social services agency~~ The commissioner shall conduct a review of ~~all child welfare~~ ten percent of each responsible social services agency's child protection cases for African American and other disproportionately represented children handled by ~~the agency. Each responsible social services agency shall create a summary report of trends identified under paragraphs (b) and (c), a remediation plan as provided in paragraph (d), and an update on implementation of any previous remediation plans. The first report shall be provided to the African American Child Well-Being Advisory Council, the commissioner, and the chairs and ranking minority members of the legislative committees with jurisdiction over child welfare by October 1, 2029, and annually thereafter. For purposes of determining outcomes in this subdivision, responsible social services agencies shall use guidance from the commissioner. The commissioner shall provide guidance starting on November 1, 2028, and annually thereafter~~ responsible social services agencies.

Responsible social services agencies must provide the commissioner with any information requested for the purposes of this subdivision in a form and within a time frame prescribed by the commissioner.

(b) The case review must include:

(1) the number of African American and disproportionately represented children represented in the county child ~~welfare~~ protection system;

(2) the number and sources of maltreatment reports received and reports screened in for investigation or referred for family assessment and the race of the children and parents or custodians involved in each report;

(3) the number and race of children and parents or custodians who receive in-home preventive case management services;

(4) the number and race of children whose parents or custodians are referred to community-based, culturally appropriate, strength-based, or trauma-informed services;

(5) the number and race of children removed from their homes;

(6) the number and race of children reunified with their parents or custodians;

(7) the number and race of children whose parents or custodians are offered family group decision-making services;

(8) the number and race of children whose parents or custodians are offered the parent support outreach program;

(9) the number and race of children in foster care or out-of-home placement at the time that the data is gathered;

(10) the number and race of children who achieve permanency through a transfer of permanent legal and physical custody to a relative or an adoption; and

(11) the number and race of children who are under the guardianship of the commissioner or awaiting a permanency disposition.

(c) The required case review must also:

(1) identify barriers to reunifying children with their families;

(2) identify the family conditions that led to the out-of-home placement;

(3) identify any barriers to accessing culturally informed mental health or substance use disorder treatment services for the parents or children;

(4) document efforts to identify fathers and maternal and paternal relatives and to provide services to custodial and noncustodial fathers, if appropriate; and

(5) document and summarize court reviews of active efforts.

(d) For any responsible social services agency ~~that has~~ the commissioner identifies in a case review as showing ~~disproportionality and~~ disparities in child welfare outcomes for African American and other disproportionately represented children and the children's families~~,~~ compared to the agency's overall outcomes, the commissioner must ~~include in their case review summary report~~ develop a remediation plan with the agency with measurable outcomes to identify, address, and reduce the factors that led to the ~~disproportionality and~~ disparities in the agency's child welfare outcomes. The remediation plan shall also include information about how the responsible social services agency will achieve and document trauma-informed, positive child well-being outcomes through remediation efforts.

(e) The commissioner shall create a summary report of trends identified under paragraphs (b) and (c), a summary of remediation plans developed as provided in paragraph (d), and an update on implementation of any previous remediation plans. The commissioner shall provide the first report to the African American Child Well-Being Advisory Council, the responsible social services agencies, and the chairs and ranking minority members of the legislative committees with jurisdiction over children, youth, and families by October 1, 2029, and annually thereafter.

Sec. 6. Minnesota Statutes 2024, section 260.69, subdivision 1, is amended to read:

Subdivision 1. **Applicability.** (a) The commissioner of children, youth, and families must collaborate with the Children's Justice Initiative to ensure that cultural competency training is given or made available to individuals working in the child welfare system, including child welfare workers and supervisors. Training ~~must~~ developed by the Child Welfare Training Academy may also be made available to attorneys, juvenile court judges, guardians ad litem, and family law judges. The commissioner must give priority to child welfare workers and supervisors for in-person trainings or other trainings with limited attendance or availability.

(b) This subdivision does not require the commissioner or the Child Welfare Training Academy to develop or provide training specifically for attorneys, juvenile court judges, guardians ad litem, family law judges, or any other individuals beyond the primary training audiences required to be served under Laws 2019, First Special Session chapter 9, article 1, section 37, subdivision 2, paragraph (e).

Sec. 7. Minnesota Statutes 2025 Supplement, section 260.691, subdivision 1, is amended to read:

Subdivision 1. **Establishment and duties.** (a) The African American Child and Family Well-Being Advisory Council is established for the Department of Children, Youth, and Families.

(b) The council shall consist of 31 members appointed by the commissioner and must include representatives with lived personal or professional experience within African American communities. Members may include but are not limited to youth who have exited the child welfare system; parents; legal custodians; relative and kinship caregivers or foster care providers; community service providers, advocates, and members; county and private social services agency case managers; representatives from faith-based institutions; academic professionals; a representative from the Council for Minnesotans of African Heritage; the Ombudsperson for African American Families; and other individuals with experience and knowledge of African American communities. Council members must be selected through an open appointments process under section 15.0597. The terms, compensation, and removal of council members are governed by section 15.059.

(c) The council must:

(1) review annual reports related to African American children involved in the child welfare system. These reports may include but are not limited to the maltreatment, out-of-home placement, and permanency of African American children;

(2) assist with and make recommendations to the commissioner for developing strategies to reduce maltreatment determinations, prevent unnecessary out-of-home placement, promote culturally appropriate foster care and shelter or facility placement decisions and settings for African American children in need of out-of-home placement, ensure timely achievement of permanency, and improve child welfare outcomes for African American children and their families;

(3) review summary reports on targeted case reviews prepared by the commissioner to ensure that responsible social services agencies meet the needs of African American children and their families. Based on data collected from those reviews, the council shall assist the commissioner with developing strategies needed to improve any identified child welfare outcomes, including but not limited to maltreatment, out-of-home placement, and permanency for African American children;

(4) make recommendations to the commissioner and the legislature for public policy and statutory changes that specifically consider the needs of African American children and their families involved in the child welfare system;

(5) advise the commissioner on stakeholder engagement strategies and actions that the commissioner and responsible social services agencies may take to improve child welfare outcomes for African American children and their families;

(6) assist the commissioner with developing strategies for public messaging and communication related to racial ~~disproportionality and~~ disparities in child welfare outcomes for African American children and their families;

(7) assist the commissioner with identifying and developing internal and external partnerships to support adequate access to services and resources for African American children and their families, including but not limited to housing assistance, employment assistance, food and nutrition support, health care, child care assistance, and educational support and training; and

(8) assist the commissioner with developing strategies to promote the development of a culturally diverse and representative child welfare workforce in Minnesota that includes professionals who are reflective of the community served and who have been directly impacted by lived experiences within the child welfare system. The council must also assist the commissioner with exploring strategies and partnerships to address education and training needs, hiring, recruitment, retention, and professional advancement practices.

Sec. 8. Minnesota Statutes 2025 Supplement, section 260.692, subdivision 1, is amended to read:

Subdivision 1. **Duties.** The African American Child and Family Well-Being Unit, currently established by the commissioner, must:

(1) assist with the development of African American cultural competency training and review child welfare curriculum in the Minnesota Child Welfare Training Academy to ensure that responsible social services agency staff and other child welfare professionals are appropriately prepared to engage with African American children and their families and to support family preservation and reunification;

(2) provide technical assistance, including on-site technical assistance, and case consultation to responsible social services agencies to assist agencies with implementing and complying with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act;

(3) monitor individual county and statewide disaggregated and nondisaggregated data to identify trends and patterns in child welfare outcomes, including but not limited to reporting, maltreatment, out-of-home placement, and permanency of African American children and develop strategies to address ~~disproportionality and~~ disparities in the child welfare system;

(4) develop and implement a system for conducting case reviews when the commissioner receives reports of noncompliance with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act or when requested by the parent or custodian of an African American child. Case reviews may include but are not limited to a review of placement prevention efforts, safety planning, case planning and service provision by the responsible social services agency, relative placement consideration, and permanency planning;

(5) establish and administer a request for proposals process for African American and disproportionately represented family preservation grants under section 260.693, monitor grant activities, and provide technical assistance to grantees;

(6) in coordination with the African American Child and Family Well-Being Advisory Council, coordinate services and create internal and external partnerships to support adequate access to services and resources for African American children and their families, including but not limited to housing assistance, employment assistance, food and nutrition support, health care, child care assistance, and educational support and training; and

(7) develop public messaging and communication to inform the public about racial disparities in child welfare outcomes, current efforts and strategies to reduce racial disparities, and resources available to African American children and their families involved in the child welfare system.

Sec. 9. Minnesota Statutes 2025 Supplement, section 260.692, subdivision 2, is amended to read:

Subd. 2. **Case reviews.** (a) The African American Child and Family Well-Being Unit must conduct systemic case reviews to monitor targeted child welfare outcomes, including but not limited to maltreatment, out-of-home placement, and permanency of African American children.

(b) The reviews under this subdivision must be conducted using a random sampling of representative child ~~welfare~~ protection cases stratified for certain case related factors, including but not limited to case type, maltreatment type, if the case involves out-of-home

placement, and other demographic variables. In conducting the reviews, unit staff may use court records and documents, information from the social services information system, and other available case file information to complete the case reviews.

(c) The frequency of the reviews and the number of cases, child welfare outcomes, and selected counties reviewed shall be determined by the unit in consultation with the African American Child and Family Well-Being Advisory Council, with consideration given to the availability of unit resources needed to conduct the reviews.

(d) The unit must monitor all case reviews and use the collective case review information and data to generate summary case review reports, ensure compliance with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act, and identify trends or patterns in child welfare outcomes for African American children.

(e) The unit must review information from members of the public received through the compliance and feedback portal, including policy and practice concerns related to individual child ~~welfare~~ protection cases. After assessing a case concern, the unit may determine if further necessary action should be taken, which may include coordinating case remediation with other relevant child welfare agencies in accordance with data privacy laws, including the African American Child and Family Well-Being Advisory Council, and offering case consultation and technical assistance to the responsible local social services agency as needed or requested by the agency.

Sec. 10. Minnesota Statutes 2025 Supplement, section 260.692, subdivision 3, is amended to read:

Subd. 3. **Reports.** (a) The African American Child and Family Well-Being Unit must provide regular updates on unit activities, including summary reports of case reviews, to the African American Child and Family Well-Being Advisory Council, and must publish an annual census of African American children in out-of-home placements statewide. The annual census must include data on the types of placements, age and sex of the children, how long the children have been in out-of-home placements, and other relevant demographic information.

(b) The African American Child and Family Well-Being Unit shall gather summary data about the practice and policy inquiries and individual case concerns received through the compliance and feedback portal under subdivision 2, paragraph (e). The unit shall provide regular reports of the nonidentifying compliance and feedback portal summary data to the African American Child and Family Well-Being Advisory Council to identify child welfare

trends and patterns to assist with developing policy and practice recommendations to support eliminating ~~disparity and disproportionality~~ disparities for African American children.

Sec. 11. Minnesota Statutes 2024, section 260.693, subdivision 2, is amended to read:

Subd. 2. **Eligible services.** (a) Services eligible for grants under this section include but are not limited to:

(1) child out-of-home placement prevention and reunification services;

(2) family-based services and reunification therapy;

(3) culturally specific individual and family counseling;

(4) court advocacy;

(5) training for and consultation to responsible social services agencies and private social services agencies regarding this act;

(6) development and promotion of culturally informed, affirming, and responsive community-based prevention and family preservation services that target the children, youth, families, and communities of African American and African heritage experiencing the highest disparities~~, disproportionality,~~ and overrepresentation in the Minnesota child welfare system;

(7) culturally affirming and responsive services that work with children and families in their communities to address their needs and ensure child and family safety and well-being within a culturally appropriate lens and framework;

(8) services to support informal kinship care arrangements; and

(9) other activities and services approved by the commissioner that further the goals of the Minnesota African American Family Preservation and Child Welfare Disproportionality Act, including but not limited to the recruitment of African American staff and staff from other communities disproportionately represented in the child welfare system to work for responsible social services agencies and licensed child-placing agencies.

(b) The commissioner may specify the priority of an activity and service based on its success in furthering these goals. The commissioner shall give preference to programs and service providers that are located in or serve counties with the highest rates of child welfare ~~disproportionality~~ disproportionate representation for African American and other disproportionately represented children and their families and employ staff who represent the population primarily served.

Sec. 12. Laws 2024, chapter 117, section 21, is amended to read:

Sec. 21. **MINNESOTA AFRICAN AMERICAN FAMILY PRESERVATION AND CHILD WELFARE DISPROPORTIONALITY ACT; WORKING GROUP.**

(a) The commissioner of human services must establish a working group to provide guidance and oversight for the Minnesota African American Family Preservation and Child Welfare Disproportionality Act phase-in program.

(b) The members of the working group must include representatives from the Minnesota Association of County Social Service Administrators, the Association of Minnesota Counties, the Minnesota Inter-County Association, the Minnesota County Attorneys Association, Hennepin County, Ramsey County, the Department of Human Services, and community organizations with experience in child welfare. The legislature may provide recommendations to the commissioner on the selection of the representatives from the community organizations.

(c) The working group must provide oversight of the phase-in program and evaluate the cost of the phase-in program. The working group must also assess future costs of implementing the Minnesota African American Family Preservation and Child Welfare Disproportionality Act statewide.

(d) By January 1, 2026, the working group must develop and submit an interim report to the chairs and ranking minority members of the legislative committees with jurisdiction over child welfare detailing initial needs for the implementation of the Minnesota African American Family Preservation and Child Welfare Disproportionality Act. The interim report must also include recommendations for any statutory or policy changes necessary to implement the act.

(e) By September 1, 2026, the working group must develop an implementation plan and best practices for the Minnesota African American Family Preservation and Child Welfare Disproportionality Act to go into effect statewide.

(f) The working group under this section expires December 31, 2027.

Sec. 13. **REPEALER.**

Minnesota Statutes 2024, section 260.63, subdivision 9, is repealed.

ARTICLE 9
MISCELLANEOUS

Section 1. Minnesota Statutes 2024, section 62Q.096, is amended to read:

62Q.096 CREDENTIALING OF PROVIDERS.

(a) If a health plan company has initially credentialed, as providers in its provider network, individual providers employed by or under contract with an entity that:

(1) is authorized to bill under section 256B.0625, subdivision 5;

(2) is a mental health clinic certified under section 245I.20;

(3) is designated an essential community provider under section 62Q.19; and

(4) is under contract with the health plan company to provide mental health services, the health plan company must continue to credential at least the same number of providers from that entity, as long as those providers meet the health plan company's credentialing standards.

(b) In order to ensure timely access by patients to mental health services, ~~between July 1, 2023, and June 30, 2025,~~ a health plan company must credential and enter into a contract for mental health services with any provider of mental health services that:

(1) meets the health plan company's credential requirements. For purposes of credentialing under this paragraph, a health plan company may waive credentialing requirements that are not directly related to quality of care in order to ensure patient access to providers from underserved communities or to providers in rural areas;

(2) seeks to receive a credential from the health plan company;

(3) agrees to the health plan company's contract terms. The contract shall include payment rates that are usual and customary for the services provided;

(4) is accepting new patients; and

(5) is not already under a contract with the health plan company under a separate tax identification number or, if already under a contract with the health plan company, has provided notice to the health plan company of termination of the existing contract.

(c) A health plan company shall not refuse to credential these providers on the grounds that their provider network has:

(1) a sufficient number of providers of that type, including but not limited to the provider types identified in paragraph (a); or

(2) a sufficient number of providers of mental health services in the aggregate.

Sec. 2. **[256.0141] HUMAN SERVICES SYSTEMS STEERING COMMITTEE.**

Subdivision 1. **Establishment.** The Human Services Systems Steering Committee is established to provide recommendations to the commissioners of human services, information technology services, and children, youth, and families on the development, administration, and business operations of human services information technology systems. For the purposes of this section, "human services systems" means any information technology system used by counties, or the commissioners of human services and children, youth, and families.

Subd. 2. **Membership; costs.** (a) The steering committee must be composed of the following members:

(1) two members appointed by the commissioner of human services;

(2) two members appointed by the commissioner of children, youth, and families;

(3) six members appointed jointly by the Association of Minnesota Counties, the Minnesota Inter-County Association, and the Minnesota Association of County Social Service Administrators; and

(4) two nonvoting members appointed by the commissioner of information technology services.

(b) One member appointed under paragraph (a), clause (3), and one member appointed under paragraph (a), clause (4), must serve as cochairpersons for the steering committee.

(c) Steering committee costs must be paid and reimbursed for expenses as provided in section 15.0575 from the budgets of the Department of Human Services, the Department of Information Technology Services, and the Department of Children, Youth, and Families.

(d) The commissioner of information technology services must organize and administer the steering committee.

Subd. 3. **Duties.** (a) The steering committee must provide recommendations on the administration and business operations of current human services systems and the development of any new human services systems.

(b) For each human services system, the steering committee must make recommendations on setting system goals and priorities, allocating system resources, making major system decisions, and tracking total system funding and expenditures from all sources.

(c) The steering committee must provide monthly updates on the committee's duties under this subdivision to the Legislative Commission on Human Services Systems under section 256.0142.

Subd. 4. **Meetings.** (a) The steering committee must meet at least quarterly.

(b) As part of every steering committee meeting, the steering committee must provide the opportunity for oral and written public testimony and comments on steering committee recommendations.

(c) All votes of the steering committee must be recorded, with each member's vote identified.

Subd. 5. **Implementation of changes; new systems.** (a) The commissioners of human services and children, youth, and families must not implement new major changes to current human services systems, or implement a new human services system, prior to receiving recommendations from the steering committee and consulting with counties on the changes or development.

(b) The commissioners of human services and children, youth, and families must implement changes to human services systems recommended and passed by at least seven members of the steering committee.

Subd. 6. **Report.** (a) Beginning January 30, 2027, and each January 30 thereafter, the steering committee must report to the Legislative Commission on Human Services Systems under section 256.0142, and to the chairs and ranking minority members of the legislative committees with jurisdiction over human services systems. The report must include:

(1) for each human services system, system funding and expenditures, including amounts received in the previous calendar year by funding source and expenditures made in the previous calendar year by funding source;

(2) recommendations made by the steering committee under subdivision 3, including any draft legislation to implement the recommendations; and

(3) a list of projects needed to improve human services systems.

(b) The legislative committees with jurisdiction over human services systems must hold a public hearing on the report during the regular legislative session in the year in which the report was submitted.

Sec. 3. **[256.0142] LEGISLATIVE COMMISSION ON HUMAN SERVICES SYSTEMS.**

Subdivision 1. **Establishment; duties.** (a) The Legislative Commission on Human Services Systems is created to:

(1) provide oversight and monitoring of the efforts by the counties and the Departments of Human Services; Information Technology Services; and Children, Youth, and Families to manage, develop, update, and modernize information technology systems across human services programs, including, but not limited to: MAXIS, METS, MMIS, SSIS, PRISM, and MEC2;

(2) evaluate Minnesota's state-supervised, county-administered human services system and provide recommendations for changes, if applicable. This must include evaluating changes to roles and responsibilities for the administration and delivery of human services programs and services, including program eligibility, case management functions, and use of third-party and nongovernmental entities;

(3) review how other states procure, administer, and deliver human services programs and services and the information technology infrastructure utilized;

(4) identify areas within the governance, procurement, and technology structures of the human services system that need to be addressed by the legislature;

(5) review reports provided to the legislature from state agencies on information technology projects and human services system transformation; and

(6) review reports and updates provided to the commission by the Human Services Systems Steering Committee under section 256.0141.

(b) The commission must work with Minnesota's Tribal Nations, counties, and the Departments of Human Services; Information Technology Services; and Children, Youth, and Families to:

(1) evaluate proposals for modifications to information technology systems utilized by Minnesota's Tribal Nations, counties, or the Departments of Human Services and Children, Youth, and Families; and

(2) consider overall costs to the state, counties, and Tribal Nations for the implementation of any systems changes, and assess whether proposed solutions deliver improved services to Minnesotans and administrative responsibilities are efficiently delegated across stakeholders.

Subd. 2. **Members; meetings.** (a) Members of the legislative commission must include:

(1) six members from the house of representatives, including three members appointed by the speaker of the house and three members appointed by the minority leader; and

(2) six members from the senate, including three members appointed by the senate majority leader and three members appointed by the senate minority leader.

(b) Members of the commission serve a term that expires on December 31 of the even-numbered year following the year they are appointed. The speaker of the house and the majority leader of the senate must each designate a chair and vice-chair from the membership of the commission. The chair and vice-chair must rotate after each meeting.

(c) The commission must meet at least quarterly.

Subd. 3. **Administrative support.** The Legislative Coordinating Commission must provide administrative support to the commission and arrange meeting space for commission meetings.

Subd. 4. **Report.** By February 15, 2027, and annually thereafter, the commission, in cooperation with the commissioners of human services; information technology services; and children, youth, and families, must provide a report to the chairs and ranking minority members of the legislative committees with jurisdiction over human services and children, youth, and families. The report must contain information on the results of the commission's evaluations, identifications, and reviews under subdivision 1; recommendations for any legislative changes, including any draft legislation to implement the recommendations; and funding needs to implement any recommended changes.

Subd. 5. **Expiration.** This commission expires December 31, 2033.

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

Sec. 4. **HUMAN SERVICES STEERING COMMITTEE; FIRST APPOINTMENTS AND FIRST MEETING.**

Appointing authorities for the Human Services Steering Committee under Minnesota Statutes, section 256.0141, must make first appointments to the steering committee by August 15, 2026. The commissioner of information technology services must convene the first meeting of the committee by September 15, 2026.

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

Sec. 5. **LEGISLATIVE COMMISSION ON HUMAN SERVICES SYSTEMS; FIRST APPOINTMENTS AND FIRST MEETING.**

Appointing authorities for the Legislative Commission on Human Services Systems under Minnesota Statutes, section 256.0142, must make first appointments to, and designate the chairs and vice-chairs of, the Legislative Commission on Human Services Systems by August 15, 2026. The member designated as chair by the majority leader of the senate must convene the first meeting of the commission by September 15, 2026.

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

Amend the title accordingly