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

Delete everything after the enacting clause and insert:

"ARTICLE 1
HEALTH CARE

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

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

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

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

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

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

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

(3) the individual designated as the compliance officer under section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

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

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

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

(b) Controlling individual does not include:

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

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

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

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

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

2.10 (4) an individual who is a member of an organization exempt from taxation under section
2.11 290.05, unless the individual is also an officer, owner, or managerial official of the program
2.12 or owns any of the beneficial interests not excluded in this subdivision. This clause does
2.13 not exclude from the definition of controlling individual an organization that is exempt from
2.14 taxation; or

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

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

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

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

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

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

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

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

3.3 (2) the individual designated as the authorized agent under section 245A.04, subdivision
3.4 1, paragraph (b);

3.5 (3) the individual designated as the compliance officer under section ~~256B.04, subdivision~~
3.6 ~~21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

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

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

3.10 (b) Controlling individual does not include:

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

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

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

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

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

3.23 (4) an individual who is a member of an organization exempt from taxation under section
3.24 290.05, unless the individual is also an officer, owner, or managerial official of the program
3.25 or owns any of the beneficial interests not excluded in this subdivision. This clause does
3.26 not exclude from the definition of controlling individual an organization that is exempt from
3.27 taxation; or

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

3.31 (c) For purposes of this subdivision, "managerial official" means an individual who has
3.32 the decision-making authority related to the operation of the program, and the responsibility

4.1 for the ongoing management of or direction of the policies, services, or employees of the
4.2 program. A site director who has no ownership interest in the program is not considered to
4.3 be a managerial official for purposes of this definition.

4.4 Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.04, subdivision 1, is amended
4.5 to read:

4.6 Subdivision 1. **Application for licensure.** (a) An individual, organization, or government
4.7 entity that is subject to licensure under section 245A.03 must apply for a license. The
4.8 application must be made on the forms and in the manner prescribed by the commissioner.
4.9 The commissioner shall provide the applicant with instruction in completing the application
4.10 and provide information about the rules and requirements of other state agencies that affect
4.11 the applicant. An applicant seeking licensure in Minnesota with headquarters outside of
4.12 Minnesota must have a program office located within 30 miles of the Minnesota border.
4.13 An applicant who intends to buy or otherwise acquire a program or services licensed under
4.14 this chapter that is owned by another license holder must apply for a license under this
4.15 chapter and comply with the application procedures in this section and section 245A.043.

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

4.23 When the commissioner receives an application for initial licensure that is incomplete
4.24 because the applicant failed to submit required documents or that is substantially deficient
4.25 because the documents submitted do not meet licensing requirements, the commissioner
4.26 shall provide the applicant written notice that the application is incomplete or substantially
4.27 deficient. In the written notice to the applicant the commissioner shall identify documents
4.28 that are missing or deficient and give the applicant 45 days to resubmit a second application
4.29 that is substantially complete. An applicant's failure to submit a substantially complete
4.30 application after receiving notice from the commissioner is a basis for license denial under
4.31 section 245A.043.

4.32 (b) An application for licensure must identify all controlling individuals as defined in
4.33 section 245A.02, subdivision 5a, and must designate one individual to be the authorized
4.34 agent. The application must be signed by the authorized agent and must include the authorized

5.1 agent's first, middle, and last name; mailing address; and email address. By submitting an
5.2 application for licensure, the authorized agent consents to electronic communication with
5.3 the commissioner throughout the application process. The authorized agent must be
5.4 authorized to accept service on behalf of all of the controlling individuals. A government
5.5 entity that holds multiple licenses under this chapter may designate one authorized agent
5.6 for all licenses issued under this chapter or may designate a different authorized agent for
5.7 each license. Service on the authorized agent is service on all of the controlling individuals.
5.8 It is not a defense to any action arising under this chapter that service was not made on each
5.9 controlling individual. The designation of a controlling individual as the authorized agent
5.10 under this paragraph does not affect the legal responsibility of any other controlling individual
5.11 under this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

6.15 (3) the first, middle, and last name, and address for all individuals who will be controlling
6.16 individuals, including all officers, owners, and managerial officials as defined in section
6.17 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant
6.18 for each controlling individual;

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

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

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

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

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

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

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

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

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

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

7.11 (2) noncompliance with the provider enrollment agreement or registration requirements
7.12 for receipt of public funding that is identified through a licensing investigation or licensing
7.13 inspection, or noncompliance with a licensing requirement that is a basis of enrollment for
7.14 reimbursement for a service, may result in:

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

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

7.19 (iii) recovery of payments made for the service;

7.20 (iv) disenrollment in the public payment program; or

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

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

7.28 (1) the application;

7.29 (2) the renewal;

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

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

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

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

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

8.9 (1) the name of the license holder;

8.10 (2) the address of the program;

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

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

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

8.15 (6) any special conditions of licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

9.25 (h) The commissioner shall not issue or reissue a license under this chapter if an individual
9.26 living in the household where the services will be provided as specified under section
9.27 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside
9.28 and no variance has been granted.

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

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

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

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

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

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

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

10.28 **245A.05 DENIAL OF APPLICATION.**

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

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

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

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

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

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

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

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

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

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

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

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

(b) An applicant whose application has been denied by the commissioner must be given notice of the denial, which must state the reasons for the denial in plain language. Notice must be given by certified mail, by personal service, or through the provider licensing and reporting hub. The notice must state the reasons the application was denied and must inform the applicant of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The applicant may appeal the denial by notifying the commissioner in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within 20 calendar days after the applicant received the notice of denial. If an appeal request is made by personal service, it must be received by the commissioner within 20 calendar days after the applicant received the notice of denial. If the order is issued through the provider hub, the appeal must be received by the commissioner within 20

calendar days from the date the commissioner issued the order through the hub. Section 245A.08 applies to hearings held to appeal the commissioner's denial of an application.

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

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

(1) maintaining a current understanding of the licensing requirements sufficient to ensure compliance throughout the program as identified in section 245A.04, subdivision 1, paragraph (e), and when applicable, as identified in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision 7;

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

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

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

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

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

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

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

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

13.3 Sec. 9. Minnesota Statutes 2025 Supplement, section 256.01, subdivision 2, is amended
13.4 to read:

13.5 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision 2,
13.6 the commissioner of human services shall carry out the specific duties in paragraphs (a)
13.7 through (z):

13.8 (a) Administer and supervise the forms of public assistance provided for by state law
13.9 and other welfare activities or services that are vested in the commissioner. Administration
13.10 and supervision of human services activities or services includes, but is not limited to,
13.11 assuring timely and accurate distribution of benefits, completeness of service, and quality
13.12 program management. In addition to administering and supervising human services activities
13.13 vested by law in the department, the commissioner shall have the authority to:

13.14 (1) require county agency participation in training and technical assistance programs to
13.15 promote compliance with statutes, rules, federal laws, regulations, and policies governing
13.16 human services;

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

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

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

13.26 (5) delay or deny payment of all or part of the state and federal share of benefits and
13.27 administrative reimbursement according to the procedures set forth in section 256.017;

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

13.30 (7) enter into contractual agreements with federally recognized Indian Tribes with a
13.31 reservation in Minnesota to the extent necessary for the Tribe to operate a federally approved
13.32 family assistance program or any other program under the supervision of the commissioner.

14.1 The commissioner shall consult with the affected county or counties in the contractual
14.2 agreement negotiations, if the county or counties wish to be included, in order to avoid the
14.3 duplication of county and Tribal assistance program services. The commissioner may
14.4 establish necessary accounts for the purposes of receiving and disbursing funds as necessary
14.5 for the operation of the programs.

14.6 The commissioner shall work in conjunction with the commissioner of children, youth, and
14.7 families to carry out the duties of this paragraph when necessary and feasible.

14.8 (b) Inform county agencies, on a timely basis, of changes in statute, rule, federal law,
14.9 regulation, and policy necessary to county agency administration of the programs.

14.10 (c) Administer and supervise all noninstitutional service to persons with disabilities,
14.11 including persons who have vision impairments, and persons who are deaf, deafblind, and
14.12 hard-of-hearing or with other disabilities. The commissioner may provide and contract for
14.13 the care and treatment of qualified indigent children in facilities other than those located
14.14 and available at state hospitals operated by the executive board when it is not feasible to
14.15 provide the service in state hospitals operated by the executive board.

14.16 (d) Assist and actively cooperate with other departments, agencies and institutions, local,
14.17 state, and federal, by performing services in conformity with the purposes of Laws 1939,
14.18 chapter 431.

14.19 (e) Act as the agent of and cooperate with the federal government in matters of mutual
14.20 concern relative to and in conformity with the provisions of Laws 1939, chapter 431,
14.21 including the administration of any federal funds granted to the state to aid in the performance
14.22 of any functions of the commissioner as specified in Laws 1939, chapter 431, and including
14.23 the promulgation of rules making uniformly available medical care benefits to all recipients
14.24 of public assistance, at such times as the federal government increases its participation in
14.25 assistance expenditures for medical care to recipients of public assistance, the cost thereof
14.26 to be borne in the same proportion as are grants of aid to said recipients.

14.27 (f) Establish and maintain any administrative units reasonably necessary for the
14.28 performance of administrative functions common to all divisions of the department.

14.29 (g) Act as designated guardian of both the estate and the person of all the wards of the
14.30 state of Minnesota, whether by operation of law or by an order of court, without any further
14.31 act or proceeding whatever, except as to persons committed as developmentally disabled.

14.32 (h) Act as coordinating referral and informational center on requests for service for
14.33 newly arrived immigrants coming to Minnesota.

15.1 (i) The specific enumeration of powers and duties as hereinabove set forth shall in no
15.2 way be construed to be a limitation upon the general transfer of powers herein contained.

15.3 (j) Establish county, regional, or statewide schedules of maximum fees and charges
15.4 which may be paid by county agencies for medical, dental, surgical, hospital, nursing and
15.5 nursing home care and medicine and medical supplies under all programs of medical care
15.6 provided by the state and for congregate living care under the income maintenance programs.

15.7 (k) Have the authority to conduct and administer experimental projects to test methods
15.8 and procedures of administering assistance and services to recipients or potential recipients
15.9 of public welfare. To carry out such experimental projects, it is further provided that the
15.10 commissioner of human services is authorized to waive the enforcement of existing specific
15.11 statutory program requirements, rules, and standards in one or more counties. The order
15.12 establishing the waiver shall provide alternative methods and procedures of administration,
15.13 shall not be in conflict with the basic purposes, coverage, or benefits provided by law, and
15.14 in no event shall the duration of a project exceed four years. It is further provided that no
15.15 order establishing an experimental project as authorized by the provisions of this section
15.16 shall become effective until the following conditions have been met:

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

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

15.21 (l) According to federal requirements and in coordination with the commissioner of
15.22 children, youth, and families, establish procedures to be followed by local welfare boards
15.23 in creating citizen advisory committees, including procedures for selection of committee
15.24 members.

15.25 (m) Allocate federal fiscal disallowances or sanctions which are based on quality control
15.26 error rates for medical assistance in the following manner:

15.27 (1) one-half of the total amount of the disallowance shall be borne by the county boards
15.28 responsible for administering the programs. Disallowances shall be shared by each county
15.29 board in the same proportion as that county's expenditures for the sanctioned program are
15.30 to the total of all counties' expenditures for medical assistance. Each county shall pay its
15.31 share of the disallowance to the state of Minnesota. When a county fails to pay the amount
15.32 due hereunder, the commissioner may deduct the amount from reimbursement otherwise
15.33 due the county, or the attorney general, upon the request of the commissioner, may institute
15.34 civil action to recover the amount due; and

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

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

16.15 (o) Have the authority to establish and enforce the following county reporting
16.16 requirements:

16.17 (1) the commissioner shall establish fiscal and statistical reporting requirements necessary
16.18 to account for the expenditure of funds allocated to counties for human services programs.
16.19 When establishing financial and statistical reporting requirements, the commissioner shall
16.20 evaluate all reports, in consultation with the counties, to determine if the reports can be
16.21 simplified or the number of reports can be reduced;

16.22 (2) the county board shall submit monthly or quarterly reports to the department as
16.23 required by the commissioner. Monthly reports are due no later than 15 working days after
16.24 the end of the month. Quarterly reports are due no later than 30 calendar days after the end
16.25 of the quarter, unless the commissioner determines that the deadline must be shortened to
16.26 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss
16.27 of federal funding. Only reports that are complete, legible, and in the required format shall
16.28 be accepted by the commissioner;

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

17.1 (4) a county board that submits reports that are late, illegible, incomplete, or not in the
17.2 required format for two out of three consecutive reporting periods is considered
17.3 noncompliant. When a county board is found to be noncompliant, the commissioner shall
17.4 notify the county board of the reason the county board is considered noncompliant and
17.5 request that the county board develop a corrective action plan stating how the county board
17.6 plans to correct the problem. The corrective action plan must be submitted to the
17.7 commissioner within 45 days after the date the county board received notice of
17.8 noncompliance;

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

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

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

17.23 (p) Allocate federal fiscal disallowances or sanctions for audit exceptions when federal
17.24 fiscal disallowances or sanctions are based on a statewide random sample in direct proportion
17.25 to each county's claim for that period.

17.26 (q) Be responsible for ensuring the detection, prevention, investigation, and resolution
17.27 of fraudulent activities or behavior by applicants, recipients, and other participants in the
17.28 human services programs administered by the department, including but not limited to a
17.29 preenrollment risk assessment. A preenrollment risk assessment under this paragraph must
17.30 be conducted in accordance with the procedures and criteria established in section 256B.0437.

17.31 (r) Require county agencies to identify overpayments, establish claims, and utilize all
17.32 available and cost-beneficial methodologies to collect and recover these overpayments in
17.33 the human services programs administered by the department.

18.1 (s) Have the authority to administer the federal drug rebate program for drugs purchased
18.2 under the medical assistance program as allowed by section 1927 of title XIX of the Social
18.3 Security Act and according to the terms and conditions of section 1927. Rebates shall be
18.4 collected for all drugs that have been dispensed or administered in an outpatient setting and
18.5 that are from manufacturers who have signed a rebate agreement with the United States
18.6 Department of Health and Human Services.

18.7 (t) Have the authority to administer a supplemental drug rebate program for drugs
18.8 purchased under the medical assistance program. The commissioner may enter into
18.9 supplemental rebate contracts with pharmaceutical manufacturers and may require prior
18.10 authorization for drugs that are from manufacturers that have not signed a supplemental
18.11 rebate contract. Prior authorization of drugs shall be subject to the provisions of section
18.12 256B.0625, subdivision 13.

18.13 (u) Operate the department's communication systems account established in Laws 1993,
18.14 First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared
18.15 communication costs necessary for the operation of the programs the commissioner
18.16 supervises. Each account must be used to manage shared communication costs necessary
18.17 for the operations of the programs the commissioner supervises. The commissioner may
18.18 distribute the costs of operating and maintaining communication systems to participants in
18.19 a manner that reflects actual usage. Costs may include acquisition, licensing, insurance,
18.20 maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit
18.21 organizations and state, county, and local government agencies involved in the operation
18.22 of programs the commissioner supervises may participate in the use of the department's
18.23 communications technology and share in the cost of operation. The commissioner may
18.24 accept on behalf of the state any gift, bequest, devise or personal property of any kind, or
18.25 money tendered to the state for any lawful purpose pertaining to the communication activities
18.26 of the department. Any money received for this purpose must be deposited in the department's
18.27 communication systems accounts. Money collected by the commissioner for the use of
18.28 communication systems must be deposited in the state communication systems account and
18.29 is appropriated to the commissioner for purposes of this section.

18.30 (v) Receive any federal matching money that is made available through the medical
18.31 assistance program for the consumer satisfaction survey. Any federal money received for
18.32 the survey is appropriated to the commissioner for this purpose. The commissioner may
18.33 expend the federal money received for the consumer satisfaction survey in either year of
18.34 the biennium.

19.1 (w) Designate community information and referral call centers and incorporate cost
19.2 reimbursement claims from the designated community information and referral call centers
19.3 into the federal cost reimbursement claiming processes of the department according to
19.4 federal law, rule, and regulations. Existing information and referral centers provided by
19.5 Greater Twin Cities United Way or existing call centers for which Greater Twin Cities
19.6 United Way has legal authority to represent, shall be included in these designations upon
19.7 review by the commissioner and assurance that these services are accredited and in
19.8 compliance with national standards. Any reimbursement is appropriated to the commissioner
19.9 and all designated information and referral centers shall receive payments according to
19.10 normal department schedules established by the commissioner upon final approval of
19.11 allocation methodologies from the United States Department of Health and Human Services
19.12 Division of Cost Allocation or other appropriate authorities.

19.13 (x) Develop recommended standards for adult foster care homes that address the
19.14 components of specialized therapeutic services to be provided by adult foster care homes
19.15 with those services.

19.16 (y) Authorize the method of payment to or from the department as part of the human
19.17 services programs administered by the department. This authorization includes the receipt
19.18 or disbursement of funds held by the department in a fiduciary capacity as part of the human
19.19 services programs administered by the department.

19.20 (z) Designate the agencies that operate the Senior LinkAge Line under section 256.975,
19.21 subdivision 7, and the Disability Hub under subdivision 24 as the state of Minnesota Aging
19.22 and Disability Resource Center under United States Code, title 42, section 3001, the Older
19.23 Americans Act Amendments of 2006, and incorporate cost reimbursement claims from the
19.24 designated centers into the federal cost reimbursement claiming processes of the department
19.25 according to federal law, rule, and regulations. Any reimbursement must be appropriated
19.26 to the commissioner and treated consistent with section 256.011. All Aging and Disability
19.27 Resource Center designated agencies shall receive payments of grant funding that supports
19.28 the activity and generates the federal financial participation according to Board on Aging
19.29 administrative granting mechanisms.

19.30 Sec. 10. **[256.0113] ELIGIBILITY TO RECEIVE PUBLIC MONEY; PRE-AWARD**
19.31 **RISK ASSESSMENT.**

19.32 Subdivision 1. **Pre-award risk assessment; grant recipients.** (a) Prior to receiving a
19.33 grant award for a program administered by the commissioner, a potential grantee must

20.1 provide the commissioner with the applicable information specified under section 16B.981,
20.2 subdivision 2, for the most recent three-year period. This information must also include:

20.3 (1) the potential grantee's history of performing services during the most recent three-year
20.4 period that are substantially similar to the services the potential grantee is seeking to receive
20.5 public funds to provide; and

20.6 (2) for a potential grantee that is a for-profit business or nonprofit organization, evidence
20.7 of registration and good standing with the secretary of state for the most recent three-year
20.8 period, if applicable.

20.9 (b) For any information not submitted to the commissioner as required under this section
20.10 because the potential grantee determined it to be inapplicable, the potential grantee must
20.11 submit documentation noting each item that was not submitted and the reason why the
20.12 potential grantee determined it was inapplicable.

20.13 Subd. 2. **Pre-award risk assessment; licensure.** (a) Prior to renewing a license for a
20.14 program administered by the commissioner, a provider, vendor, or individual must provide
20.15 the commissioner with the applicable information specified under section 16B.981,
20.16 subdivision 2, for the most recent licensure period.

20.17 (b) Notwithstanding paragraph (a), for a provider, vendor, or individual who has been
20.18 licensed in a program administered by the commissioner for at least three years, the provider,
20.19 vendor, or individual must provide the commissioner with the applicable information
20.20 specified under section 16B.981, subdivision 2, for the most recent three-year period.

20.21 (c) For any information not submitted to the commissioner as required under this section
20.22 because the provider, vendor, or individual determined it to be inapplicable, the provider,
20.23 vendor, or individual must submit documentation noting each item that was not submitted
20.24 and the reason why the provider, vendor, or individual determined it was inapplicable.

20.25 Subd. 3. **Pre-award risk assessment; reenrollment and revalidation.** (a) Prior to
20.26 reenrollment or revalidation in a program administered by the commissioner, a provider,
20.27 vendor, or individual must provide the commissioner with the applicable information
20.28 specified under section 16B.981, subdivision 2, for the most recent enrollment period.

20.29 (b) Notwithstanding paragraph (a), for a provider, vendor, or individual who has been
20.30 enrolled in a program administered by the commissioner for at least three years, the provider,
20.31 vendor, or individual must provide the commissioner with the applicable information
20.32 specified under section 16B.981, subdivision 2, for the most recent three-year period.

21.1 (c) For any information not submitted to the commissioner as required under this section
21.2 because the provider, vendor, or individual determined it to be inapplicable, the provider,
21.3 vendor, or individual must submit documentation noting each item that was not submitted
21.4 and the reason why the provider, vendor, or individual determined it was inapplicable.

21.5 Subd. 4. **Commissioner duties.** (a) The commissioner must review all information
21.6 provided under subdivisions 1 to 3 prior to awarding a grant, renewing a license, or
21.7 reenrolling or revalidating a provider, vendor, or individual. For any documentation submitted
21.8 to the commissioner under subdivision 1, paragraph (b); subdivision 2, paragraph (c); or
21.9 subdivision 3, paragraph (c), the commissioner must review and confirm that the
21.10 determination of inapplicability made by the potential grantee or the provider, vendor, or
21.11 individual is correct. For any incorrect determination, the potential grantee or the provider,
21.12 vendor, or individual must submit the required information prior to receiving grant funds,
21.13 renewing a license, reenrollment in a program, or revalidation.

21.14 (b) Notwithstanding section 16B.981, if, after reviewing the information provided under
21.15 subdivision 1, the commissioner has concerns that there is a substantial risk that a potential
21.16 grantee cannot or would not perform the required duties under the grant agreement, the
21.17 commissioner must not award the grant.

21.18 (c) If, after reviewing the information provided under subdivision 2 or 3, the
21.19 commissioner has concerns that there is a substantial risk that the provider, vendor, or
21.20 individual seeking to renew a license, or applying for reenrollment or revalidation, cannot
21.21 or would not perform the necessary duties required under the license or enrollment agreement,
21.22 the commissioner must deny the license renewal or terminate the participation of the provider,
21.23 vendor, or individual in the program.

21.24 Sec. 11. Minnesota Statutes 2024, section 256B.02, is amended by adding a subdivision
21.25 to read:

21.26 Subd. 20. **Fraud.** "Fraud" means an intentional deception or misrepresentation made by
21.27 a person with the knowledge that the deception could result in an unauthorized benefit to
21.28 the person or another person. Fraud includes:

21.29 (1) the following crimes, including attempts or conspiracy to commit the crimes:

21.30 (i) theft in violation of section 609.52;

21.31 (ii) perjury in violation of section 609.48;

21.32 (iii) aggravated forgery and forgery in violation of sections 609.625 and 609.63;

22.1 (iv) medical assistance fraud in violation of section 609.466;

22.2 (v) financial transaction card fraud in violation of section 609.821;

22.3 (vi) wrongfully obtaining assistance in violation of section 256.98;

22.4 (vii) illegal remunerations in violation of section 609.542; and

22.5 (viii) a felony listed in United States Code, title 42, section 1320a-7b(b)(1) or (2), subject
22.6 to any safe harbors established in Code of Federal Regulations, title 42, part 1001, section
22.7 952;

22.8 (2) any act that constitutes fraud under applicable federal or state law, including but not
22.9 limited to knowingly and willfully submitting an application for provider status that is false
22.10 or fraudulent in whole or in part; and

22.11 (3) an intentional submission of a claim for reimbursement under chapter 256B, knowing
22.12 or having reason to know the claim is ineligible for reimbursement in whole or in part and
22.13 acting with the intent to defraud the payor.

22.14 Sec. 12. Minnesota Statutes 2025 Supplement, section 256B.04, subdivision 21, is amended
22.15 to read:

22.16 Subd. 21. **Provider enrollment.** ~~(a)~~ The commissioner shall enroll providers and conduct
22.17 screening activities as required by sections 256B.044 to 256B.0445 and Code of Federal
22.18 Regulations, title 42, section 455, subpart E.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Sec. 13. **[256B.0437] PREENROLLMENT ASSESSMENT.**

(a) Before enrolling a provider or agency, the commissioner may complete a preenrollment risk assessment of the provider or agency seeking to enroll to confirm the provider or agency's eligibility and the provider or agency's ability to meet the requirements of this chapter. The commissioner must utilize a risk-score framework as a component of the assessment that identifies service-specific fraud risk indicators, including but not limited to organizational readiness, financial stability, compliance history, and addressing service necessity.

(b) Based on the assessment of fraud risk indicators described in paragraph (a), the commissioner may deem the applicant ineligible and deny or rescind enrollment. The decision to deny or rescind enrollment must be made in writing and sent using a signature-verified confirmed delivery method. An applicant may request reconsideration of the decision regarding the applicant's eligibility in writing within 30 business days after the date the notice was issued. The commissioner must notify each applicant of the commissioner's final decision regarding the applicant's eligibility.

(c) A provider enrolled before July 1, 2026, that billed for services on or after January 1, 2025, must receive a positive preenrollment risk assessment no later than July 1, 2027, to remain eligible. A provider or agency enrolled before July 1, 2026, that has not billed

27.1 for services on or after January 1, 2025, must receive a positive preenrollment risk assessment
27.2 no later than July 1, 2026, to remain eligible. A provider that becomes ineligible under this
27.3 paragraph regains eligibility after receiving a positive assessment under this section if the
27.4 provider remains otherwise eligible.

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

27.6 Sec. 14. **[256B.044] PROVIDER ENROLLMENT.**

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

27.12 (b) The list and criteria are not subject to the requirements of chapter 14, and section
27.13 14.386 does not apply.

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

27.15 Subd. 2. **Service location enrollment.** A provider must enroll each provider-controlled
27.16 location where direct services are provided.

27.17 Subd. 3. **Incomplete provider enrollment applications.** The commissioner may deny
27.18 a provider's incomplete enrollment application if a provider fails to respond to the
27.19 commissioner's request for additional information within 60 days of the request.

27.20 Subd. 4. **Required background studies.** (a) The commissioner must conduct a
27.21 background study under chapter 245C, including a review of databases in section 245C.08,
27.22 subdivision 1, paragraph (a), clauses (1) to (5), for a provider applying for enrollment under
27.23 section 256B.04, subdivision 21. The background study requirement may be satisfied if the
27.24 commissioner conducted a fingerprint-based background study on the provider that included
27.25 a review of databases in section 245C.08, subdivision 1, paragraph (a), clauses (1) to (5).

27.26 (b) As a condition of enrollment in medical assistance, the commissioner must require
27.27 that a high-risk provider, or a person with a direct or indirect ownership interest in the
27.28 provider of five percent or higher, consent to criminal background checks, including
27.29 fingerprinting, when required to do so under state law or by a determination by the
27.30 commissioner or the Centers for Medicare and Medicaid Services (CMS) that a provider is
27.31 designated high-risk.

28.1 Subd. 5. **Surety bonds.** (a) The commissioner may require a provider to purchase a
28.2 surety bond as a condition of initial enrollment, revalidation, reenrollment, reinstatement,
28.3 or continued enrollment if:

28.4 (1) the provider fails to demonstrate financial viability;

28.5 (2) the commissioner determines there is significant evidence of or potential for fraud
28.6 and abuse by the provider; or

28.7 (3) the provider or category of providers is designated high-risk pursuant to subdivision
28.8 1 and Code of Federal Regulations, title 42, section 455.450.

28.9 (b) The surety bond must be in an amount of $100,000 or ten percent of the provider's
28.10 payments from Medicaid during the immediately preceding 12 months, whichever is greater.
28.11 The surety bond must name the Department of Human Services as an obligee, must be
28.12 purchased new annually, and must allow for recovery of costs and fees in pursuing a claim
28.13 on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must
28.14 occur within six years from the date the debt is affirmed by a final agency decision. An
28.15 agency decision is final when the right to appeal the debt has been exhausted or the time to
28.16 appeal has expired under section 256B.064.

28.17 (c) This subdivision does not apply if the provider currently maintains a surety bond
28.18 under the requirements in section 256B.051, 256B.0659, 256B.0701, or 256B.85.

28.19 Subd. 6. **Required on-site inspections.** (a) As a condition of enrollment in medical
28.20 assistance, the commissioner shall require that a provider designated moderate-risk or
28.21 high-risk by CMS or the commissioner permit CMS, CMS's agents, or CMS's designated
28.22 contractors and the state agency, the state agency's agents, or the state agency's designated
28.23 contractors to conduct unannounced on-site inspections of any provider location.

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

28.28 Subd. 7. **Compliance programs.** (a) The commissioner may require, as a condition of
28.29 enrollment in medical assistance, that a provider within a particular industry sector or
28.30 category establish a compliance program that contains the core elements established by
28.31 CMS.

28.32 (b) If an enrolled provider is required by the commissioner or by law to designate an
28.33 individual as the provider's compliance officer, the compliance officer must:

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

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

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

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

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

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

29.14 Subd. 8. **Correspondence and notification.** The commissioner may deliver
29.15 correspondence and notifications, including notifications of termination and other actions,
29.16 electronically to a provider's MN-ITS mailbox. This subdivision does not apply to
29.17 correspondence and notifications related to background studies.

29.18 Sec. 15. **[256B.0441] PROVIDER REVALIDATION.**

29.19 Subdivision 1. **Provider revalidation schedule.** The commissioner shall revalidate:

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

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

29.24 (3) each early intensive developmental and behavioral intervention agency at least once
29.25 every three years; and

29.26 (4) at the commissioner's discretion, any medical-assistance-only provider type the
29.27 commissioner deems high-risk under section 256B.044, subdivision 1.

29.28 Subd. 2. **Revalidation procedures.** The commissioner shall conduct revalidation as
29.29 follows:

29.30 (1) provide 30 days' notice of the revalidation due date including instructions for
29.31 revalidation and a list of materials the provider must submit; and

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

30.4 Sec. 16. **[256B.0442] PROVIDER ENROLLMENT SUSPENSIONS AND**
30.5 **TERMINATIONS.**

30.6 Subdivision 1. **Commissioner's general authority to suspend individual provider's**
30.7 **enrollment.** (a) If a provider fails to comply with any individual provider requirement or
30.8 condition of participation, the commissioner may suspend the provider's ability to bill until
30.9 the provider comes into compliance.

30.10 (b) The commissioner's decision to suspend the provider is not subject to an administrative
30.11 appeal.

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

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

30.23 Subd. 3. **Commissioner's duty to terminate provider enrollment.** (a) Except as
30.24 provided in paragraph (b), the commissioner must terminate or deny the enrollment of any
30.25 individual or entity if the individual or entity has been terminated from participation in
30.26 Medicare or under the Medicaid program or Children's Health Insurance Program of any
30.27 other state.

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

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

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

31.1 (3) serves primarily a pediatric population.

31.2 Subd. 4. **Commissioner's authority to terminate provider enrollment for lack of**
31.3 **submitted claims.** The commissioner may terminate the enrollment of an individual or
31.4 entity provider if the individual or entity provider has not submitted any claims in the
31.5 previous 12 consecutive calendar months.

31.6 Sec. 17. **[256B.0443] PROVIDER PAYMENT WITHHOLDS.**

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

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

31.13 Sec. 18. **[256B.0444] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
31.14 **FOR HIGH-RISK PROVIDERS.**

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

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

31.27 (b) New owners active in day-to-day management and operations of the agency and new
31.28 managerial and supervisory employees of the agency must complete compliance training
31.29 under this subdivision within 30 calendar days of becoming an owner of or employed by
31.30 the agency and prior to conducting any management and operations activities for the agency.
31.31 If an individual moves to another agency providing the same service and serves in a similar
31.32 ownership or employment capacity, the individual is not required to repeat the training

32.1 required under this subdivision. If the individual chooses not to repeat the compliance
32.2 training, the individual must provide the agency with documentation proving the individual
32.3 completed the compliance training within the provider revalidation schedule for the relevant
32.4 provider type as determined by the commissioner under section 256B.0441.

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

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

32.9 (2) enrollment requirements;

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

32.11 (4) fair labor standards;

32.12 (5) workplace safety requirements; and

32.13 (6) recent changes in service requirements.

32.14 Subd. 3. **Individual provider number.** (a) Effective January 1, 2027, all individuals
32.15 subject to a background study as a result of being employed by or an owner of a high-risk
32.16 agency must enroll individually as a medical assistance provider.

32.17 (b) The commissioner must issue a unique Minnesota provider identifier to each
32.18 individual who satisfies the background study requirements, satisfies the individual
32.19 enrollment requirements, and does not have either a national provider identifier or a unique
32.20 Minnesota provider identifier. The commissioner must ensure that no individual is issued
32.21 multiple unique Minnesota provider identifiers. If the commissioner mistakenly issues
32.22 multiple unique Minnesota provider identifiers to the same individual, the commissioner
32.23 must provide a means for the numbers to be consolidated.

32.24 (c) If an individual provides false or misleading information to the commissioner in an
32.25 attempt to cause the commissioner to issue to the individual an additional unique Minnesota
32.26 provider identifier, the commissioner may terminate the enrollment of the individual.

32.27 Sec. 19. **[256B.0445] ADDITIONAL PROVIDER ENROLLMENT REQUIREMENTS**
32.28 **FOR SPECIFIC PROVIDER TYPES.**

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

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

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

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

33.22 Subd. 2. **Providers licensed by the commissioner of human services.** An enrolled
33.23 provider that is also licensed by the commissioner under chapter 245A must designate an
33.24 individual as the licensee's compliance officer under section 256B.044, subdivision 7,
33.25 paragraph (b).

33.26 Subd. 3. **Providers licensed by the commissioner of health.** An enrolled provider that
33.27 is also licensed by the commissioner of health as a home care provider under chapter 144A
33.28 with a home and community-based services designation under section 144A.484 on the
33.29 home care license, or as an assisted living facility under chapter 144G, must designate an
33.30 individual as the licensee's compliance officer under section 256B.044, subdivision 7,
33.31 paragraph (b).

34.1 Sec. 20. **[256B.0447] PREPAYMENT REVIEW.**

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

34.5 Subd. 2. **Notice.** (a) Except as provided in paragraph (b), the commissioner must provide
34.6 written notice to a provider placed under prepayment review at least 60 days before the
34.7 review is implemented. The notice must include:

34.8 (1) the basis for the review; and

34.9 (2) the effective date of the review.

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

34.13 Subd. 3. **Continued enrollment of new clients.** Nothing in this section prohibits an
34.14 enrolled provider that is subject to prepayment review from enrolling new clients or
34.15 beneficiaries during the period of review unless otherwise prohibited by law or by a separate
34.16 action of the commissioner.

34.17 Subd. 4. **Timely claims processing.** The commissioner must conduct prepayment review
34.18 in a manner consistent with Code of Federal Regulations, title 42, section 447.45.

34.19 Subd. 5. **Relationship to other actions.** Prepayment review under this section does not
34.20 preclude the commissioner from conducting a preliminary investigation, full investigation,
34.21 payment suspension, postpayment review, audit, overpayment recovery, sanction, or referral
34.22 to law enforcement under this chapter or under applicable federal law.

34.23 Subd. 6. **Phase-in.** The commissioner must develop a process to phase in the prepayment
34.24 review process under this section based on provider volume, with high-volume providers
34.25 subject to prepayment review first.

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

34.27 Sec. 21. **[256B.0448] POSTPAYMENT REVIEW.**

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

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

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

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

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

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

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

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

35.22 Sec. 22. **[256B.0639] ACCESS TO RECORDS AND SERVICE LOCATIONS.**

35.23 (a) The commissioner may conduct on-site inspections of any and all vendors of medical
35.24 care and the vendor's service locations. The vendor must give the commissioner immediate
35.25 access without prior notice to the vendor's offices and service locations during regular
35.26 business hours. The commissioner may request records and documents during an on-site
35.27 inspection or by making a written request to the vendor. The commissioner may use the
35.28 records and documents to verify the accuracy of any information submitted by the vendor
35.29 to the commissioner, to determine compliance with service delivery and billing requirements,
35.30 or to determine compliance with any other applicable laws or rules. Failing to provide the
35.31 commissioner with immediate access to records or documents or failing to comply with a
35.32 written request for records or documents, is a refusal under section 256B.064, subdivision

36.1 1a, paragraph (a), clause (5), and is cause for the vendor's immediate suspension of payment
36.2 and termination under section 256B.064.

36.3 (b) Section 256B.27, subdivisions 4 and 5, apply to actions taken by the commissioner
36.4 under this section. Notwithstanding any other law to the contrary, a vendor of medical care
36.5 shall not be subject to any civil or criminal liability for providing access to medical records
36.6 to the commissioner of human services pursuant to this section.

36.7 Sec. 23. Minnesota Statutes 2025 Supplement, section 256B.064, subdivision 1a, is
36.8 amended to read:

36.9 Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against
36.10 any individual or entity that receives payments from medical assistance or provides goods
36.11 or services for which payment is made from medical assistance for any of the following:

36.12 (1) fraud, theft, or abuse in connection with the provision of goods and services to
36.13 recipients of public assistance for which payment is made from medical assistance;

36.14 (2) a pattern of presentment of false or duplicate claims or claims for services not
36.15 medically necessary;

36.16 (3) a pattern of making false statements of material facts for the purpose of obtaining
36.17 greater compensation than that to which the individual or entity is legally entitled;

36.18 (4) suspension or termination as a Medicare vendor;

36.19 (5) refusal to grant the state agency access during regular business hours to examine all
36.20 records necessary to disclose the extent of services provided to program recipients and
36.21 appropriateness of claims for payment;

36.22 (6) failure to repay an overpayment provided in section 256B.0641 or a fine finally
36.23 established under this section;

36.24 (7) failure to correct errors in the maintenance of health service or financial records for
36.25 which a fine was imposed or after issuance of a warning by the commissioner; and

36.26 (8) any reason for which an individual or entity could be excluded from participation in
36.27 the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act.

36.28 (b) For the purposes of this section, goods or services for which payment is made from
36.29 medical assistance includes but is not limited to care and services identified in section
36.30 256B.0625 or provided pursuant to any federally approved waiver.

(c) Regardless of the source of payment or other item of value, the commissioner may impose sanctions against any individual or entity that solicits, receives, pays, or offers to pay any illegal remuneration as described in section 142E.51, subdivision 6a, in violation of section 609.542, subdivision 2, or in violation of United States Code, title 42, section 1320a-7b(b)(1) or (2). No conviction is required before the commissioner can impose sanctions under this paragraph.

(d) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey under section 256B.0625, subdivision 13e, paragraph (g).

(e) The commissioner may impose sanctions against a pharmacy provider for failure to respond to a Minnesota drug acquisition cost survey under section 256B.0625, subdivision 13e, paragraph (i).

Sec. 24. Minnesota Statutes 2024, section 256B.064, subdivision 1b, is amended to read:

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

(1) suspending payments to an individual or entity;

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

(3) suspending participation in the program;

(4) terminating participation in the program; or

(5) imposing a fine under subdivision 2a.

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

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

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

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

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

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

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

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

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

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

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

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

38.27 Sec. 27. Minnesota Statutes 2024, section 256B.064, subdivision 2, is amended to read:

38.28 Subd. 2. **Imposition of monetary recovery and sanctions; generally.** (a) The
38.29 commissioner ~~shall~~ must determine any monetary amounts to be recovered and sanctions
38.30 to be imposed upon an individual or entity under this section. Except as provided in
38.31 ~~paragraphs (b) and (d), neither~~ subdivision 2c, the commissioner must not obtain a monetary

recovery ~~nor~~ or impose a sanction ~~will be imposed by the commissioner~~ without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to an individual or entity, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

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

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

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

~~(i) fraud hotline complaints;~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

41.3 (5) other information required by the commissioner.

41.4 ~~(g) The commissioner may order an individual or entity to forfeit a fine for failure to~~
41.5 ~~fully document services according to standards in this chapter and Minnesota Rules, chapter~~
41.6 ~~9505. The commissioner may assess fines if specific required components of documentation~~
41.7 ~~are missing. The fine for incomplete documentation shall equal 20 percent of the amount~~
41.8 ~~paid on the claims for reimbursement submitted by the individual or entity, or up to $5,000,~~
41.9 ~~whichever is less. If the commissioner determines that an individual or entity repeatedly~~
41.10 ~~violated this chapter, chapter 254B or 245G, or Minnesota Rules, chapter 9505, related to~~
41.11 ~~the provision of services to program recipients and the submission of claims for payment,~~
41.12 ~~the commissioner may order an individual or entity to forfeit a fine based on the nature,~~
41.13 ~~severity, and chronicity of the violations, in an amount of up to $5,000 or 20 percent of the~~
41.14 ~~value of the claims, whichever is greater.~~

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

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

41.20 Sec. 28. Minnesota Statutes 2024, section 256B.064, is amended by adding a subdivision
41.21 to read:

41.22 Subd. 2a. **Imposition of fines.** (a) The commissioner may order an individual or entity
41.23 to forfeit a fine for failure to fully document services according to standards in this chapter
41.24 and Minnesota Rules, chapter 9505. The commissioner may assess fines if specific required
41.25 components of documentation are missing. The fine for incomplete documentation equals
41.26 20 percent of the amount paid on the claims for reimbursement submitted by the individual
41.27 or entity, or up to $5,000, whichever is less.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

42.30 (2) the commissioner determines there is a credible allegation of fraud for which an
42.31 investigation is pending under the program. Allegations are considered credible when the

43.1 allegations have indicia of reliability and the commissioner has reviewed all allegations,
43.2 facts, and evidence carefully and acts judiciously on a case-by-case basis.

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

43.5 (1) fraud hotline complaints;

43.6 (2) complaints from service recipients, guardians of service recipients, and case managers
43.7 of service recipients;

43.8 (3) claims data mining;

43.9 (4) patterns identified through provider audits, civil false claims cases, law enforcement
43.10 investigations, and investigations by other state or federal agencies; and

43.11 (5) court filings or other legal documents.

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

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

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

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

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

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

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

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

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

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

44.12 (b) The cost of the review under paragraph (c) must be paid by the individual or entity.

44.13 (c) The burden of proof upon appeal of a temporary withhold is limited to whether the
44.14 commissioner can establish there is a credible allegation of fraud as provided in subdivision
44.15 2c, paragraph (a), clause (2). The administrative law judge's recommendation to the
44.16 commissioner must not make findings on the veracity of the underlying allegations of fraud,
44.17 as the underlying investigation remains ongoing and underlying facts may be litigated in
44.18 future administrative, civil, or criminal proceedings when a final agency decision is issued.

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

44.25 (e) The commissioner must provide notice to the individual or entity when the
44.26 administrative law judge makes a recommendation. The notice must be sent within ten
44.27 business days of the administrative law judge's completed recommendation and must state
44.28 that the appeal process under this subdivision is completed.

44.29 (f) The administrative law judge's findings of facts, conclusions of law, and
44.30 recommendation as to whether there is a credible allegation of fraud, may not be used or
44.31 considered for any other purpose, including impeachment, in any civil, criminal,
44.32 administrative, or contractual proceeding. The administrative law judge's findings of facts,
44.33 conclusions of law, and recommendation may not be held conclusive or binding or used as
44.34 evidence in any separate or subsequent action in any other forum, be it contractual,

administrative, or judicial, regardless of whether the action involves the same or related parties or involves the same facts.

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

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

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

Sec. 33. Minnesota Statutes 2024, section 256B.064, subdivision 3, is amended to read:

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

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

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

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

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

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

(3) other fines or penalties allowed by law.

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

Sec. 34. Minnesota Statutes 2024, section 256B.064, subdivision 4, is amended to read:

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

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

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

Sec. 35. Minnesota Statutes 2024, section 256B.064, subdivision 5, is amended to read:

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

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

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

(d) After an investigation is complete, the reporter's name must be kept confidential. The subject of the report may compel disclosure of the reporter's name only with the consent of the reporter or upon a written finding by a district court that the report was false and there

47.1 is evidence that the report was made in bad faith. This subdivision does not alter disclosure
47.2 responsibilities or obligations under the Rules of Criminal Procedure, except that when the
47.3 identity of the reporter is relevant to a criminal prosecution the district court ~~shall~~ must
47.4 conduct an in-camera review before determining whether to order disclosure of the reporter's
47.5 identity.

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

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

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

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

47.12 Sec. 37. **[256B.0647] REMITTANCE ADVICE MONETARY RECOVERY.**

47.13 (a) The commissioner may use the remittance advice process under Code of Federal
47.14 Regulations, title 45, part 162.1601, as the notice to a vendor or provider when seeking
47.15 monetary recovery using a department-administered information technology system for
47.16 programmatically processed claims. The remittance advice must be delivered electronically
47.17 and constitutes the sole notice to the provider. The commissioner must withhold the payments
47.18 at issue when using the remittance advice as the notice.

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

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

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

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

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

<u>(5) other information required by the commissioner.</u>

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

Sec. 38. Minnesota Statutes 2025 Supplement, section 256B.0759, subdivision 4, is amended to read:

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

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

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

(d) Effective January 1, 2021, and contingent on annual federal approval, managed care plans and county-based purchasing plans must reimburse providers of the substance use disorder services meeting the criteria described in paragraph (a) who are employed by or under contract with the plan an amount that is at least equal to the fee-for-service base rate payment for the substance use disorder services described in paragraph (c). The commissioner must monitor the effect of this requirement on the rate of access to substance use disorder

services and residential substance use disorder rates. Capitation rates paid to managed care organizations and county-based purchasing plans must reflect the impact of this requirement. This paragraph expires if federal approval is not received at any time as required under this paragraph.

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

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

Sec. 39. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is amended to read:

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

(1) enroll as a medical assistance Minnesota health care program provider according to Minnesota Rules, part 9505.0195, and ~~section 256B.04, subdivision 21~~ sections 256B.044 to 256B.0445, and meet all applicable provider standards and requirements;

(2) designate an individual as the agency's compliance officer who must perform the duties described in section ~~256B.04, subdivision 21, paragraph (g)~~ 256B.044, subdivision 7, paragraph (b);

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

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

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

50.1 individuals or entities maintained by the federal Department of Human Services Office of
50.2 Inspector General;

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

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

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

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

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

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

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

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

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

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

50.30 (16) provide required EIDBI intervention observation and direction at least once per
50.31 month. Notwithstanding subdivision 13, paragraph (l), required EIDBI intervention
50.32 observation and direction under this clause may be conducted via telehealth provided that

51.1 no more than two consecutive monthly required EIDBI intervention observation and direction
51.2 sessions under this clause are conducted via telehealth.

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

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

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

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

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

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

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

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

51.21 Sec. 40. Minnesota Statutes 2024, section 256B.0949, subdivision 17, is amended to read:

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

52.1 the state, or statewide. The commissioner shall also consider the availability of various types
52.2 of treatment modalities covered under this section.

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

52.10 (1) EIDBI provider qualifications under this section;

52.11 (2) medical assistance provider enrollment requirements under ~~section 256B.04,~~
52.12 ~~subdivision 21~~ sections 256B.044 to 256B.0445; or

52.13 (3) EIDBI provider or agency standards or requirements.

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

52.23 Sec. 41. Minnesota Statutes 2024, section 256B.69, subdivision 5a, is amended to read:

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

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

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

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

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

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

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

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

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

54.5 (e) Effective for services rendered on or after January 1, 2013, through December 31,
54.6 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
54.7 this section and county-based purchasing plan payments under section 256B.692 for the
54.8 prepaid medical assistance program. The withheld funds must be returned no sooner than
54.9 July 1 and no later than July 31 of the following year. The commissioner may exclude
54.10 special demonstration projects under subdivision 23.

54.11 (f) Effective for services rendered on or after January 1, 2014, the commissioner shall
54.12 withhold three percent of managed care plan payments under this section and county-based
54.13 purchasing plan payments under section 256B.692 for the prepaid medical assistance
54.14 program. The withheld funds must be returned no sooner than July 1 and no later than July
54.15 31 of the following year. The commissioner may exclude special demonstration projects
54.16 under subdivision 23.

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

54.20 (h) Contracts between the commissioner and a prepaid health plan are exempt from the
54.21 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
54.22 7.

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

54.25 (j) Managed care plans and county-based purchasing plans shall maintain current and
54.26 fully executed agreements for all subcontractors, including bargaining groups, for
54.27 administrative services that are expensed to the state's public health care programs.
54.28 Subcontractor agreements determined to be material, as defined by the commissioner after
54.29 taking into account state contracting and relevant statutory requirements, must be in the
54.30 form of a written instrument or electronic document containing the elements of offer,
54.31 acceptance, consideration, payment terms, scope, duration of the contract, and how the
54.32 subcontractor services relate to state public health care programs. Upon request, the
54.33 commissioner shall have access to all subcontractor documentation under this paragraph.

55.1 Nothing in this paragraph shall allow release of information that is nonpublic data pursuant
55.2 to section 13.02.

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

55.7 Sec. 42. **MANDATORY COMPLIANCE TRAINING FOR CURRENTLY**
55.8 **ENROLLED HIGH-RISK MEDICAL ASSISTANCE PROVIDERS.**

55.9 The owners and employees of any medical assistance provider agency subject to the
55.10 requirements of Minnesota Statutes, section 256B.0444, subdivision 2, and enrolled before
55.11 January 1, 2027, must complete initial compliance training by January 1, 2028. Owners and
55.12 employees of PCA and CFSS agencies who enrolled before January 1, 2027, and have
55.13 previously completed training under Minnesota Statutes, section 256B.0659, subdivision
55.14 21, paragraph (c), or 256B.85, subdivision 12, paragraph (c), are not subject to the initial
55.15 training requirements of this section but must repeat the compliance training prior to
55.16 revalidation as a medical assistance provider.

55.17 **ARTICLE 2**

55.18 **DHS OIG POLICY**

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

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

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

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

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

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

56.1 (1) fraud hotline complaints;

56.2 (2) claims data mining;

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

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

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

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

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

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

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

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

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

56.20 Sec. 2. Minnesota Statutes 2024, section 245.095, subdivision 5, is amended to read:

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

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

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

56.30 (3) the provider is operating after a state or federal agency orders the suspension,
56.31 revocation, or decertification of the provider's license or certification, or if the provider is

57.1 subject to a temporary immediate suspension, regardless of whether the action is under
57.2 appeal; or

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

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

57.9 ~~(1) fraud hotline complaints;~~

57.10 ~~(2) claims data mining;~~

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

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

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

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

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

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

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

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

58.1 individual, or associated entity to determine whether the payment withholding should remain
58.2 in place.

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

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

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

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

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

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

58.18 Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 2, is amended
58.19 to read:

58.20 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

58.21 (1) residential or nonresidential programs that are provided to a person by an individual
58.22 who is related;

58.23 (2) nonresidential programs that are provided by an unrelated individual to persons from
58.24 a single related family;

58.25 (3) residential or nonresidential programs that are provided to adults who do not misuse
58.26 substances or have a substance use disorder, a mental illness, a developmental disability, a
58.27 functional impairment, or a physical disability;

58.28 (4) sheltered workshops or work activity programs that are certified by the commissioner
58.29 of employment and economic development;

58.30 (5) programs operated by a public school for children 33 months or older;

59.1 (6) nonresidential programs primarily for children that provide care or supervision for
59.2 periods of less than three hours a day while the child's parent or legal guardian is in the
59.3 same building as the nonresidential program or present within another building that is
59.4 directly contiguous to the building in which the nonresidential program is located;

59.5 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
59.6 under section 245A.02;

59.7 (8) board and lodge facilities licensed by the commissioner of health that do not provide
59.8 children's residential services under Minnesota Rules, chapter 2960, mental health or
59.9 substance use disorder treatment;

59.10 (9) programs licensed by the commissioner of corrections;

59.11 (10) recreation programs for children or adults that are operated or approved by a park
59.12 and recreation board whose primary purpose is to provide social and recreational activities;

59.13 (11) noncertified boarding care homes unless they provide services for five or more
59.14 persons whose primary diagnosis is mental illness or a developmental disability;

59.15 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art
59.16 programs, and nonresidential programs for children provided for a cumulative total of less
59.17 than 30 days in any 12-month period;

59.18 (13) residential programs for persons with mental illness, that are located in hospitals;

59.19 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter
59.20 4630;

59.21 (15) mental health outpatient services for adults with mental illness or children with
59.22 mental illness;

59.23 (16) residential programs serving school-age children whose sole purpose is cultural or
59.24 educational exchange, until the commissioner adopts appropriate rules;

59.25 (17) community support services programs as defined in section 245.462, subdivision
59.26 6, and family community support services as defined in section 245.4871, subdivision 17;

59.27 (18) assisted living facilities licensed by the commissioner of health under chapter 144G;

59.28 (19) substance use disorder treatment activities of licensed professionals in private
59.29 practice as defined in section 245G.01, subdivision 17;

60.1 (20) consumer-directed community support service funded under the Medicaid waiver
60.2 for persons with developmental disabilities when the individual who provided the service
60.3 is:

60.4 (i) the same individual who is the direct payee of these specific waiver funds or paid by
60.5 a fiscal agent, fiscal intermediary, or employer of record; and

60.6 (ii) not otherwise under the control of a residential or nonresidential program that is
60.7 required to be licensed under this chapter when providing the service;

60.8 (21) a county that is an eligible vendor under section 254B.0501 to provide care
60.9 coordination and comprehensive assessment services;

60.10 (22) a recovery community organization that is an eligible vendor under section
60.11 254B.0501 to provide peer recovery support services; or

60.12 (23) programs licensed by the commissioner of children, youth, and families in chapter
60.13 142B.

60.14 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
60.15 building in which a nonresidential program is located if it shares a common wall with the
60.16 building in which the nonresidential program is located or is attached to that building by
60.17 skyway, tunnel, atrium, or common roof.

60.18 (c) Except for the home and community-based services identified in section 245D.03,
60.19 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
60.20 provided and funded according to an approved federal waiver plan where licensure is
60.21 specifically identified as not being a condition for the services and funding.

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

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

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

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

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

(2) the license holder merges with another organization;

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

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

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

~~(b) For changes under paragraph (a), clause (1) or (5), no change in ownership has occurred and a new license application is not required if at least one controlling individual has been affiliated as a controlling individual for the license for at least the previous 12 months immediately preceding the change.~~

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

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

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

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

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

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

Subd. 2a. **Immediate suspension expedited hearing.** (a) Within five working days of receipt of the license holder's timely appeal, the commissioner shall request assignment of an administrative law judge. The request must include a proposed date, time, and place of a hearing. A hearing must be conducted by an administrative law judge within 30 calendar days of the request for assignment, unless an extension is requested by either party and granted by the administrative law judge for good cause. The commissioner shall issue a

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

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

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

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

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

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

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

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

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

64.1 Sec. 8. Minnesota Statutes 2025 Supplement, section 245A.07, subdivision 3, is amended
64.2 to read:

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

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

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

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

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

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

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

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

64.24 (b) If the license was suspended or revoked, the notice must inform the license holder
64.25 of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts
64.26 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking
64.27 a license. The appeal of an order suspending or revoking a license must be made in writing
64.28 by certified mail, by personal service, or through the provider licensing and reporting hub.
64.29 If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar
64.30 days after the license holder receives notice that the license has been suspended or revoked.
64.31 If a request is made by personal service, it must be received by the commissioner within
64.32 ten calendar days after the license holder received the order. If the order is issued through
64.33 the provider hub, the appeal must be received by the commissioner within ten calendar days

65.1 from the date the commissioner issued the order through the hub. Except as provided in
65.2 subdivision 2a, paragraph (c), if a license holder submits a timely appeal of an order
65.3 suspending or revoking a license, the license holder may continue to operate the program
65.4 as provided in section 245A.04, subdivision 7, paragraphs (i) and (j), until the commissioner
65.5 issues a final order on the suspension or revocation.

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

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

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

65.30 (4) Fines shall be assessed as follows:

65.31 (i) the license holder shall forfeit $1,000 for each determination of maltreatment of a
65.32 child under chapter 260E or the maltreatment of a vulnerable adult under section 626.557
65.33 for which the license holder is determined responsible for the maltreatment under section
65.34 260E.30, subdivision 4, paragraphs (a) and (b), or 626.557, subdivision 9c, paragraph (c);

66.1 (ii) if the commissioner determines that a determination of maltreatment for which the
66.2 license holder is responsible is the result of maltreatment that meets the definition of serious
66.3 maltreatment as defined in section 245C.02, subdivision 18, the license holder shall forfeit
66.4 $5,000;

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

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

66.11 For purposes of this section, "occurrence" means each violation identified in the
66.12 commissioner's fine order. Fines assessed against a license holder that holds a license to
66.13 provide home and community-based services, as identified in section 245D.03, subdivision
66.14 1, and a community residential setting or day services facility license under chapter 245D
66.15 where the services are provided, may be assessed against both licenses for the same
66.16 occurrence, but the combined amount of the fines shall not exceed the amount specified in
66.17 this clause for that occurrence.

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

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

66.30 Sec. 9. Minnesota Statutes 2024, section 256B.04, subdivision 10, is amended to read:

66.31 Subd. 10. **Investigation of certain claims.** The commissioner must establish by rule
66.32 general criteria and procedures for the identification and prompt investigation of suspected
66.33 medical assistance fraud, theft, abuse, presentment of false or duplicate claims, presentment

of claims for services not reasonable or medically necessary, or false statement or representation of material facts by a vendor of medical care~~, and for the imposition of sanctions against a vendor of medical care~~. The commissioner must utilize both prepayment and postpayment review systems to review claims submitted by vendors. Payment of claims, including payments made after a prepayment review, does not prohibit the commissioner from completing a postpayment claims review and taking additional administrative actions or monetary recovery against a vendor. If it appears to the state agency that a vendor of medical care may have acted in a manner warranting civil or criminal proceedings, it shall so inform the attorney general in writing.

Sec. 10. Minnesota Statutes 2025 Supplement, section 256B.051, subdivision 6, is amended to read:

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

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

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

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

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

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

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

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

68.5 (8) completes compliance training as required under subdivision 6b.

68.6 Sec. 11. Minnesota Statutes 2025 Supplement, section 256B.0659, subdivision 21, is
68.7 amended to read:

68.8 Subd. 21. **Requirements for provider enrollment of personal care assistance provider**
68.9 **agencies.** (a) All personal care assistance provider agencies must provide, at the time of
68.10 enrollment, reenrollment, and revalidation as a personal care assistance provider agency in
68.11 a format determined by the commissioner, information and documentation that includes,
68.12 but is not limited to, the following:

68.13 (1) the personal care assistance provider agency's current contact information including
68.14 address, telephone number, and email address;

68.15 (2) proof of surety bond coverage for each business location providing services. Upon
68.16 new enrollment, or if the provider's Medicaid revenue in the previous calendar year is up
68.17 to and including $300,000, the provider agency must purchase a surety bond of $50,000. If
68.18 the Medicaid revenue in the previous year is over $300,000, the provider agency must
68.19 purchase a surety bond of $100,000. The surety bond must be in a form approved by the
68.20 commissioner, must be ~~renewed~~ purchased new annually, and must allow for recovery of
68.21 costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or
68.22 sanctions from a surety bond must occur within six years from the date the debt is affirmed
68.23 by a final agency decision. An agency decision is final when the right to appeal the debt
68.24 has been exhausted or the time to appeal has expired under section 256B.064;

68.25 (3) proof of fidelity bond coverage in the amount of $20,000 for each business location
68.26 providing service;

68.27 (4) proof of workers' compensation insurance coverage identifying the business location
68.28 where personal care assistance services are provided;

68.29 (5) proof of liability insurance coverage identifying the business location where personal
68.30 care assistance services are provided and naming the department as a certificate holder;

68.31 (6) a copy of the personal care assistance provider agency's written policies and
68.32 procedures including: hiring of employees; training requirements; service delivery; and

69.1 employee and consumer safety including process for notification and resolution of consumer
69.2 grievances, identification and prevention of communicable diseases, and employee
69.3 misconduct;

69.4 (7) copies of all other forms the personal care assistance provider agency uses in the
69.5 course of daily business including, but not limited to:

69.6 (i) a copy of the personal care assistance provider agency's time sheet if the time sheet
69.7 varies from the standard time sheet for personal care assistance services approved by the
69.8 commissioner, and a letter requesting approval of the personal care assistance provider
69.9 agency's nonstandard time sheet;

69.10 (ii) the personal care assistance provider agency's template for the personal care assistance
69.11 care plan; and

69.12 (iii) the personal care assistance provider agency's template for the written agreement
69.13 in subdivision 20 for recipients using the personal care assistance choice option, if applicable;

69.14 (8) a list of all training and classes that the personal care assistance provider agency
69.15 requires of its staff providing personal care assistance services;

69.16 (9) documentation that the personal care assistance provider agency and staff have
69.17 successfully completed all the training required by this section, including the requirements
69.18 under subdivision 11, paragraph (d), if enhanced personal care assistance services are
69.19 provided and submitted for an enhanced rate under subdivision 17a;

69.20 (10) documentation of the agency's marketing practices;

69.21 (11) disclosure of ownership, leasing, or management of all residential properties that
69.22 is used or could be used for providing home care services;

69.23 (12) documentation that the agency will use the following percentages of revenue
69.24 generated from the medical assistance rate paid for personal care assistance services for
69.25 employee personal care assistant wages and benefits: 72.5 percent of revenue in the personal
69.26 care assistance choice option and 72.5 percent of revenue from other personal care assistance
69.27 providers. The revenue generated by the qualified professional and the reasonable costs
69.28 associated with the qualified professional shall not be used in making this calculation; and

69.29 (13) effective May 15, 2010, documentation that the agency does not burden recipients'
69.30 free exercise of their right to choose service providers by requiring personal care assistants
69.31 to sign an agreement not to work with any particular personal care assistance recipient or
69.32 for another personal care assistance provider agency after leaving the agency and that the

70.1 agency is not taking action on any such agreements or requirements regardless of the date
70.2 signed.

70.3 (b) Personal care assistance provider agencies shall provide the information specified
70.4 in paragraph (a) to the commissioner at the time the personal care assistance provider agency
70.5 enrolls as a vendor or upon request from the commissioner. The commissioner shall collect
70.6 the information specified in paragraph (a) from all personal care assistance providers
70.7 beginning July 1, 2009.

70.8 (c) All personal care assistance provider agencies shall require all employees in
70.9 management and supervisory positions and owners of the agency who are active in the
70.10 day-to-day management and operations of the agency to complete mandatory training as
70.11 determined by the commissioner before submitting an application for enrollment of the
70.12 agency as a provider. All personal care assistance provider agencies shall also require
70.13 qualified professionals to complete the training required by subdivision 13 before submitting
70.14 an application for enrollment of the agency as a provider. Employees in management and
70.15 supervisory positions and owners who are active in the day-to-day operations of an agency
70.16 who have completed the required training as an employee with a personal care assistance
70.17 provider agency do not need to repeat the required training if they are hired by another
70.18 agency, if they have completed the training within the past three years. By September 1,
70.19 2010, the required training must be available with meaningful access according to title VI
70.20 of the Civil Rights Act and federal regulations adopted under that law or any guidance from
70.21 the United States Health and Human Services Department. The required training must be
70.22 available online or by electronic remote connection. The required training must provide for
70.23 competency testing. Personal care assistance provider agency billing staff shall complete
70.24 training about personal care assistance program financial management. This training is
70.25 effective July 1, 2009. Any personal care assistance provider agency enrolled before that
70.26 date shall, if it has not already, complete the provider training within 18 months of July 1,
70.27 2009. Any new owners or employees in management and supervisory positions involved
70.28 in the day-to-day operations are required to complete mandatory training as a requisite of
70.29 working for the agency. Personal care assistance provider agencies certified for participation
70.30 in Medicare as home health agencies are exempt from the training required in this
70.31 subdivision. When available, Medicare-certified home health agency owners, supervisors,
70.32 or managers must successfully complete the competency test.

70.33 (d) All surety bonds, fidelity bonds, workers' compensation insurance, and liability
70.34 insurance required by this subdivision must be maintained continuously and purchased new
70.35 annually. After initial enrollment, a provider must submit proof of bonds and required

coverages at any time at the request of the commissioner. Services provided while there are lapses in coverage are not eligible for payment. Lapses in coverage may result in sanctions, including termination. The commissioner shall send instructions and a due date to submit the requested information to the personal care assistance provider agency.

Sec. 12. Minnesota Statutes 2025 Supplement, section 256B.0701, subdivision 9, is amended to read:

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

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

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

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

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

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

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

(7) completes compliance training as required under subdivision 11; and

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

Sec. 13. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 12, is amended to read:

Subd. 12. **Requirements for enrollment of CFSS agency-providers.** (a) All CFSS agency-providers must provide, at the time of enrollment, reenrollment, and revalidation as a CFSS agency-provider in a format determined by the commissioner, information and documentation that includes but is not limited to the following:

(1) the CFSS agency-provider's current contact information including address, telephone number, and email address;

(2) proof of surety bond coverage. Upon new enrollment, or if the agency-provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the agency-provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the agency-provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be ~~renewed~~ <u>purchased new</u> annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(3) proof of fidelity bond coverage in the amount of $20,000 per provider location;

(4) proof of workers' compensation insurance coverage;

(5) proof of liability insurance;

(6) a copy of the CFSS agency-provider's organizational chart identifying the names and roles of all owners, managing employees, staff, board of directors, and additional documentation reporting any affiliations of the directors and owners to other service providers;

(7) proof that the CFSS agency-provider has written policies and procedures including: hiring of employees; training requirements; service delivery; and employee and consumer safety, including the process for notification and resolution of participant grievances, incident response, identification and prevention of communicable diseases, and employee misconduct;

(8) proof that the CFSS agency-provider has all of the following forms and documents:

(i) a copy of the CFSS agency-provider's time sheet; and

(ii) a copy of the participant's individual CFSS service delivery plan;

73.1 (9) a list of all training and classes that the CFSS agency-provider requires of its staff
73.2 providing CFSS services;

73.3 (10) documentation that the CFSS agency-provider and staff have successfully completed
73.4 all the training required by this section;

73.5 (11) documentation of the agency-provider's marketing practices;

73.6 (12) disclosure of ownership, leasing, or management of all residential properties that
73.7 are used or could be used for providing home care services;

73.8 (13) documentation that the agency-provider will use at least the following percentages
73.9 of revenue generated from the medical assistance rate paid for CFSS services for CFSS
73.10 support worker wages and benefits: 72.5 percent of revenue from CFSS providers, except
73.11 100 percent of the revenue generated by a medical assistance rate increase due to a collective
73.12 bargaining agreement under section 179A.54 must be used for support worker wages and
73.13 benefits. The revenue generated by the worker training and development services and the
73.14 reasonable costs associated with the worker training and development services shall not be
73.15 used in making this calculation; and

73.16 (14) documentation that the agency-provider does not burden participants' free exercise
73.17 of their right to choose service providers by requiring CFSS support workers to sign an
73.18 agreement not to work with any particular CFSS participant or for another CFSS
73.19 agency-provider after leaving the agency and that the agency is not taking action on any
73.20 such agreements or requirements regardless of the date signed.

73.21 (b) CFSS agency-providers shall provide to the commissioner the information specified
73.22 in paragraph (a).

73.23 (c) All CFSS agency-providers shall require all employees in management and
73.24 supervisory positions and owners of the agency who are active in the day-to-day management
73.25 and operations of the agency to complete mandatory training as determined by the
73.26 commissioner. Employees in management and supervisory positions and owners who are
73.27 active in the day-to-day operations of an agency who have completed the required training
73.28 as an employee with a CFSS agency-provider do not need to repeat the required training if
73.29 they are hired by another agency and they have completed the training within the past three
73.30 years. CFSS agency-provider billing staff shall complete training about CFSS program
73.31 financial management. Any new owners or employees in management and supervisory
73.32 positions involved in the day-to-day operations are required to complete mandatory training
73.33 as a requisite of working for the agency.

(d) Agency-providers shall submit all required documentation in this section within 30 days of notification from the commissioner. If an agency-provider fails to submit all the required documentation, the commissioner may take action under subdivision 23a.

Sec. 14. Minnesota Statutes 2025 Supplement, section 256B.85, subdivision 17a, is amended to read:

Subd. 17a. **Consultation services provider qualifications and requirements.** Consultation services providers must meet the following qualifications and requirements:

(1) meet the requirements under subdivision 10, paragraph (a), excluding clauses (4) and (5);

(2) be under contract with the department and enrolled as a Minnesota health care program provider;

(3) not be the FMS provider, the lead agency, or the CFSS or home and community-based services waiver vendor or agency-provider to the participant;

(4) meet the service standards as established by the commissioner;

(5) have proof of surety bond coverage. Upon new enrollment, or if the consultation service provider's Medicaid revenue in the previous calendar year is less than or equal to $300,000, the consultation service provider must purchase a surety bond of $50,000. If the agency-provider's Medicaid revenue in the previous calendar year is greater than $300,000, the consultation service provider must purchase a surety bond of $100,000. The surety bond must be in a form approved by the commissioner, must be ~~renewed~~ purchased new annually, and must allow for recovery of costs and fees in pursuing a claim on the bond. Any action to obtain monetary recovery or sanctions from a surety bond must occur within six years from the date the debt is affirmed by a final agency decision. An agency decision is final when the right to appeal the debt has been exhausted or the time to appeal has expired under section 256B.064;

(6) employ lead professional staff with a minimum of two years of experience in providing services such as support planning, support broker, case management or care coordination, or consultation services and consumer education to participants using a self-directed program using FMS under medical assistance;

(7) report maltreatment as required under chapter 260E and section 626.557;

(8) comply with medical assistance provider requirements;

75.1 (9) understand the CFSS program and its policies;

75.2 (10) be knowledgeable about self-directed principles and the application of the
75.3 person-centered planning process;

75.4 (11) have general knowledge of the FMS provider duties and the vendor fiscal/employer
75.5 agent model, including all applicable federal, state, and local laws and regulations regarding
75.6 tax, labor, employment, and liability and workers' compensation coverage for household
75.7 workers; and

75.8 (12) have all employees, including lead professional staff, staff in management and
75.9 supervisory positions, and owners of the agency who are active in the day-to-day management
75.10 and operations of the agency, complete training as specified in the contract with the
75.11 department.

75.12 Sec. 15. **REPEALER.**

75.13 Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3a, is repealed.

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

75.15 **ARTICLE 3**

75.16 **BACKGROUND STUDIES**

75.17 Section 1. Minnesota Statutes 2024, section 245C.03, subdivision 3a, is amended to read:

75.18 Subd. 3a. **Personal care assistance provider agency; background studies.** Personal
75.19 care assistance provider agencies enrolled to provide personal care assistance services under
75.20 the medical assistance program must meet the following requirements:

75.21 (1) owners who have a five percent interest or more, board members, and all managing
75.22 employees are subject to a background study as provided in this chapter. This requirement
75.23 applies to currently enrolled personal care assistance provider agencies and agencies seeking
75.24 enrollment as a personal care assistance provider agency. "Managing employee" has the
75.25 same meaning as in Code of Federal Regulations, title 42, section 455.101. An organization
75.26 is barred from enrollment if:

75.27 (i) the organization has not initiated background studies of owners and managing
75.28 employees; or

75.29 (ii) the organization has initiated background studies of owners and managing employees
75.30 and the commissioner has sent the organization a notice that an owner or managing employee

76.1 of the organization has been disqualified under section 245C.14, and the owner or managing
76.2 employee has not received a set aside of the disqualification under section 245C.22; and

76.3 (2) a background study must be initiated and completed for all employee and volunteer
76.4 qualified professionals.

76.5 **EFFECTIVE DATE.** This section is effective September 15, 2026.

76.6 Sec. 2. Minnesota Statutes 2024, section 245C.03, subdivision 9, is amended to read:

76.7 Subd. 9. **Community first services and supports and financial management services**
76.8 **organizations.** Individuals affiliated with Community First Services and Supports (CFSS)
76.9 agency-providers and Financial Management Services (FMS) providers enrolled to provide
76.10 CFSS services under the medical assistance program must meet the following requirements:

76.11 (1) owners who have a five percent interest or more, board members, and all managing
76.12 employees are subject to a background study under this chapter. This requirement applies
76.13 to currently enrolled providers and agencies seeking enrollment. "Managing employee" has
76.14 the meaning given in Code of Federal Regulations, title 42, section 455.101. An organization
76.15 is barred from enrollment if:

76.16 (i) the organization has not initiated background studies of owners and managing
76.17 employees; or

76.18 (ii) the organization has initiated background studies of owners and managing employees
76.19 and the commissioner has sent the organization a notice that an owner or managing employee
76.20 of the organization has been disqualified under section 245C.14 and the owner or managing
76.21 employee has not received a set aside of the disqualification under section 245C.22;

76.22 (2) a background study must be initiated and completed for all ~~staff~~ employees or
76.23 volunteers who will have direct contact with the participant to provide worker training and
76.24 development; and

76.25 (3) a background study must be initiated and completed for all employee and volunteer
76.26 support workers.

76.27 **EFFECTIVE DATE.** This section is effective September 15, 2026.

76.28 Sec. 3. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to
76.29 read:

76.30 Subd. 17. **Providers of adult rehabilitative mental health services.** The commissioner
76.31 must conduct background studies on any individual who is an owner with an ownership

77.1 stake of at least five percent in an adult rehabilitative mental health services provider, an
77.2 operator of an adult rehabilitative mental health services provider, or an employee or
77.3 volunteer who has direct contact with people receiving adult rehabilitative mental health
77.4 services under section 256B.0623. For the purposes of this subdivision, operator includes
77.5 board members or other individuals who oversee the billing, management, or policies of
77.6 the services provided.

77.7 **EFFECTIVE DATE.** This section is effective upon implementation in NETStudy 2.0,
77.8 but no sooner than October 13, 2026.

77.9 Sec. 4. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to
77.10 read:

77.11 Subd. 18. **Providers of peer recovery services.** The commissioner must conduct
77.12 background studies on any individual who is an owner with an ownership stake of at least
77.13 five percent in a peer recovery services provider, an operator of a peer recovery service
77.14 provider, or an employee or volunteer who has direct contact with people receiving peer
77.15 recovery services under section 254B.052. For the purposes of this subdivision, operator
77.16 includes board members or other individuals who oversee the billing, management, or
77.17 policies of the services provided.

77.18 Sec. 5. Minnesota Statutes 2024, section 245C.03, is amended by adding a subdivision to
77.19 read:

77.20 Subd. 19. **Providers of adult assertive community treatment services.** The
77.21 commissioner must conduct background studies on any individual who is an owner with
77.22 an ownership stake of at least five percent in an adult assertive community treatment services
77.23 provider, an operator of an adult assertive community treatment services provider, or an
77.24 employee or volunteer who has direct contact with people receiving adult assertive
77.25 community treatment services under section 256B.0622. For the purposes of this subdivision,
77.26 operator includes board members or other individuals who oversee the billing, management,
77.27 or policies of the services provided.

77.28 **EFFECTIVE DATE.** This section is effective upon implementation in NETStudy 2.0,
77.29 but no sooner than February 16, 2027.

78.1 Sec. 6. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended
78.2 to read:

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

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

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

78.8 (i) the individual is not disqualified; or

78.9 (ii) more time is needed to complete the study but the individual is not required to be
78.10 removed from direct contact or access to people receiving services prior to completion of
78.11 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice
78.12 that more time is needed to complete the study must also indicate whether the individual is
78.13 required to be under continuous direct supervision prior to completion of the background
78.14 study. When more time is necessary to complete a background study of an individual
78.15 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,
78.16 the individual may not work in the facility or setting regardless of whether or not the
78.17 individual is supervised;

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

78.19 (3) a notice that a variance has been granted related to the individual under section
78.20 245C.30.

78.21 (b) For a background study affiliated with a licensed child care center or certified
78.22 license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii),
78.23 must not be issued until the commissioner receives a qualifying result for the individual for
78.24 the fingerprint-based national criminal history record check or the fingerprint-based criminal
78.25 history information from the Bureau of Criminal Apprehension. The notice must require
78.26 the individual to be under continuous direct supervision prior to completion of the remainder
78.27 of the background study except as permitted in subdivision 3.

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

78.29 (1) being issued a license;

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

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

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

(5) for licensed child care centers and certified license-exempt child care centers, providing direct contact services to persons served by the program;

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

(7) for background studies affiliated with a personal care provider organization, ~~except as provided in section 245C.03, subdivision 3b,~~ early intensive developmental and behavioral intervention provider, housing support or supplementary services provider, special transportation services provider, or community first services and supports provider before ~~a personal care assistant~~ an individual provides services, the ~~personal care assistance provider agency~~ entity must initiate a background study of the ~~personal care assistant~~ individual under this chapter and the ~~personal care assistance provider agency~~ entity must have received a notice from the commissioner that the ~~personal care assistant~~ individual is:

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

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

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

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

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

EFFECTIVE DATE. This section is effective September 15, 2026.

Sec. 7. Minnesota Statutes 2025 Supplement, section 245C.16, subdivision 1, is amended to read:

Subdivision 1. **Determining immediate risk of harm.** (a) If the commissioner determines that the individual studied has a disqualifying characteristic, the commissioner shall review

80.1 the information immediately available and make a determination as to the subject's immediate
80.2 risk of harm to persons served by the program where the individual studied will have direct
80.3 contact with, or access to, people receiving services.

80.4 (b) The commissioner shall consider all relevant information available, including the
80.5 following factors in determining the immediate risk of harm:

80.6 (1) the recency of the disqualifying characteristic;

80.7 (2) the recency of discharge from probation for the crimes;

80.8 (3) the number of disqualifying characteristics;

80.9 (4) the intrusiveness or violence of the disqualifying characteristic;

80.10 (5) the vulnerability of the victim involved in the disqualifying characteristic;

80.11 (6) the similarity of the victim to the persons served by the program where the individual
80.12 studied will have direct contact;

80.13 (7) whether the individual has a disqualification from a previous background study that
80.14 has not been set aside;

80.15 (8) if the individual has a disqualification which may not be set aside because it is a
80.16 permanent bar under section 245C.24, subdivision 1, or the individual is a child care
80.17 background study subject who has a felony-level conviction for a drug-related offense in
80.18 the last five years, the commissioner may order the immediate removal of the individual
80.19 from any position allowing direct contact with, or access to, persons receiving services from
80.20 the program and from working in a children's residential facility or foster residence setting;
80.21 and

80.22 (9) if the individual has a disqualification which may not be set aside because it is a
80.23 permanent bar under section 245C.24, subdivision 2, or the individual is a child care
80.24 background study subject who has a felony-level conviction for a drug-related offense during
80.25 the last five years, the commissioner may order the immediate removal of the individual
80.26 from any position allowing direct contact with or access to persons receiving services from
80.27 the center and from working in a licensed child care center or certified license-exempt child
80.28 care center.

80.29 (c) This section does not apply when the subject of a background study is regulated by
80.30 a health-related licensing board as defined in chapter 214, and the subject is determined to
80.31 be responsible for substantiated maltreatment under section 626.557 or chapter 260E.

(d) This section does not apply to a background study related to an initial application for a child foster family setting license.

(e) Except for paragraph (f), this section does not apply to a background study that is also subject to the requirements under section ~~256B.0659, subdivisions 11 and 13, for a personal care assistant or a qualified professional as defined in section 256B.0659, subdivision 1, or to a background study for an individual providing early intensive developmental and behavioral intervention services under section 256B.0949~~ <u>245C.13, subdivision 2, paragraph (c), clause (7)</u>.

(f) If the commissioner has reason to believe, based on arrest information or an active maltreatment investigation, that an individual poses an imminent risk of harm to persons receiving services, the commissioner may order that the person be continuously supervised or immediately removed pending the conclusion of the maltreatment investigation or criminal proceedings.

<u>**EFFECTIVE DATE.** This section is effective September 15, 2026.</u>

ARTICLE 4
UNIFORM SERVICE STANDARDS

Section 1. Minnesota Statutes 2024, section 245.735, subdivision 6, is amended to read:

Subd. 6. **Section 223 of the Protecting Access to Medicare Act entities.** ~~(a) The commissioner must request federal approval to participate in the demonstration program established by section 223 of the Protecting Access to Medicare Act and, if approved, to continue to participate in the demonstration program as long as federal funding for the demonstration program remains available from the United States Department of Health and Human Services. To the extent practicable, the commissioner shall align the requirements of the demonstration program with the requirements under this section for CCBHCs receiving medical assistance reimbursement under the authority of the state's Medicaid state plan. A CCBHC may not apply to participate as a billing provider in both the CCBHC federal demonstration and the benefit for CCBHCs under the medical assistance program.~~

~~(b) The commissioner must follow federal payment guidance, including payment of the CCBHC daily bundled rate for services rendered by CCBHCs to individuals who are dually eligible for Medicare and medical assistance when Medicare is the primary payer for the service. Services provided by a CCBHC operating under the authority of the state's Medicaid state plan will not receive the prospective payment system rate for services rendered by~~

82.1 ~~CCBHCs to individuals who are dually eligible for Medicare and medical assistance when~~
82.2 ~~Medicare is the primary payer for the service.~~

82.3 ~~(c)~~ Payment for services rendered by CCBHCs to individuals who have commercial
82.4 insurance as the primary payer and medical assistance as secondary payer is subject to the
82.5 requirements under section 256B.37. Services provided by a CCBHC operating under the
82.6 authority of the 223 demonstration or the state's Medicaid state plan will not receive the
82.7 prospective payment system rate for services rendered by CCBHCs to individuals who have
82.8 commercial insurance as the primary payer and medical assistance as the secondary payer.

82.9 Sec. 2. Minnesota Statutes 2025 Supplement, section 245A.03, subdivision 2, is amended
82.10 to read:

82.11 Subd. 2. **Exclusion from licensure.** (a) This chapter does not apply to:

82.12 (1) residential or nonresidential programs that are provided to a person by an individual
82.13 who is related;

82.14 (2) nonresidential programs that are provided by an unrelated individual to persons from
82.15 a single related family;

82.16 (3) residential or nonresidential programs that are provided to adults who do not misuse
82.17 substances or have a substance use disorder, a mental illness, a developmental disability, a
82.18 functional impairment, or a physical disability;

82.19 (4) sheltered workshops or work activity programs that are certified by the commissioner
82.20 of employment and economic development;

82.21 (5) programs operated by a public school for children 33 months or older;

82.22 (6) nonresidential programs primarily for children that provide care or supervision for
82.23 periods of less than three hours a day while the child's parent or legal guardian is in the
82.24 same building as the nonresidential program or present within another building that is
82.25 directly contiguous to the building in which the nonresidential program is located;

82.26 (7) nursing homes or hospitals licensed by the commissioner of health except as specified
82.27 under section 245A.02;

82.28 (8) board and lodge facilities licensed by the commissioner of health that do not provide
82.29 children's residential services under Minnesota Rules, chapter 2960, mental health or
82.30 substance use disorder treatment;

82.31 (9) programs licensed by the commissioner of corrections;

83.1 (10) recreation programs for children or adults that are operated or approved by a park
83.2 and recreation board whose primary purpose is to provide social and recreational activities;

83.3 (11) noncertified boarding care homes unless they provide services for five or more
83.4 persons whose primary diagnosis is mental illness or a developmental disability;

83.5 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art
83.6 programs, and nonresidential programs for children provided for a cumulative total of less
83.7 than 30 days in any 12-month period;

83.8 (13) residential programs for persons with mental illness, that are located in hospitals;

83.9 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter
83.10 4630;

83.11 (15) mental health outpatient services for adults with mental illness or children with
83.12 mental illness, except, effective January 1, 2028, for programs licensed under section
83.13 245A.044;

83.14 (16) residential programs serving school-age children whose sole purpose is cultural or
83.15 educational exchange, until the commissioner adopts appropriate rules;

83.16 (17) community support services programs as defined in section 245.462, subdivision
83.17 6, and family community support services as defined in section 245.4871, subdivision 17;

83.18 (18) assisted living facilities licensed by the commissioner of health under chapter 144G;

83.19 (19) substance use disorder treatment activities of licensed professionals in private
83.20 practice as defined in section 245G.01, subdivision 17;

83.21 (20) consumer-directed community support service funded under the Medicaid waiver
83.22 for persons with developmental disabilities when the individual who provided the service
83.23 is:

83.24 (i) the same individual who is the direct payee of these specific waiver funds or paid by
83.25 a fiscal agent, fiscal intermediary, or employer of record; and

83.26 (ii) not otherwise under the control of a residential or nonresidential program that is
83.27 required to be licensed under this chapter when providing the service;

83.28 (21) a county that is an eligible vendor under section 254B.0501 to provide care
83.29 coordination and comprehensive assessment services;

83.30 (22) a recovery community organization that is an eligible vendor under section
83.31 254B.0501 to provide peer recovery support services; or

84.1 (23) programs licensed by the commissioner of children, youth, and families in chapter
84.2 142B.

84.3 (b) For purposes of paragraph (a), clause (6), a building is directly contiguous to a
84.4 building in which a nonresidential program is located if it shares a common wall with the
84.5 building in which the nonresidential program is located or is attached to that building by
84.6 skyway, tunnel, atrium, or common roof.

84.7 (c) Except for the home and community-based services identified in section 245D.03,
84.8 subdivision 1, nothing in this chapter shall be construed to require licensure for any services
84.9 provided and funded according to an approved federal waiver plan where licensure is
84.10 specifically identified as not being a condition for the services and funding.

84.11 **EFFECTIVE DATE.** This section is effective January 1, 2028.

84.12 Sec. 3. **[245A.044] LICENSED NONRESIDENTIAL BEHAVIORAL HEALTH**
84.13 **SERVICES.**

84.14 Subdivision 1. **License required for certain nonresidential behavioral health**
84.15 **services.** (a) Beginning January 1, 2028, providers of nonresidential mental health and
84.16 substance use disorder services must obtain a license under this chapter to provide:

84.17 (1) adult rehabilitative mental health services under section 245I.22;

84.18 (2) children's therapeutic services and supports in the community under section 245I.30
84.19 and children's day treatment under section 245I.31;

84.20 (3) crisis response services under section 245I.24; and

84.21 (4) certified community behavioral health clinic services under section 245I.17.

84.22 (b) As a condition of licensure, an applicant or license holder must demonstrate and
84.23 maintain verification of compliance with:

84.24 (1) licensing requirements under this chapter and chapter 245I; and

84.25 (2) applicable health care program requirements under Minnesota Rules, parts 9505.0170
84.26 to 9505.0475 and 9505.2160 to 9505.2245.

84.27 Subd. 2. **Implementation.** (a) Beginning July 1, 2027, the commissioner must begin
84.28 issuing licenses to providers listed in subdivision 1. The commissioner must transition
84.29 providers certified under section 245I.011 and listed in subdivision 1 into licensure with a
84.30 phased-in schedule determined by the commissioner. The commissioner must communicate

85.1 the implementation schedule to providers at least three months before the application is
85.2 made available.

85.3 (b) Applicants for licensure must have an approved certification under section 245I.011
85.4 at least 90 days before the date of the licensure application.

85.5 (c) A provider's certification under section 245I.011, subdivision 5, paragraph (a), clauses
85.6 (2) to (4), or 6, paragraph (b), expires when the commissioner issues a decision on the
85.7 provider's license application.

85.8 (d) Upon licensure, a license holder must notify clients and staff of policies and
85.9 procedures outlined in the application.

85.10 (e) Notwithstanding paragraphs (a) and (c), subdivision 1, and sections 245I.17, 245I.22,
85.11 245I.24, 245I.30, and 245I.31, a provider listed under subdivision 1, paragraph (a), clauses
85.12 (1) to (4), and certified under section 245I.011 may continue operating past January 1, 2028,
85.13 until the commissioner issues a licensing decision if the provider submitted an application
85.14 before January 1, 2028.

85.15 (f) If a provider fails to submit an application for licensure within the time frame in
85.16 paragraph (b), the commissioner must disenroll the provider from reimbursement for the
85.17 following services:

85.18 (1) adult rehabilitative mental health services under section 256B.0623;

85.19 (2) crisis response services under section 256B.0624;

85.20 (3) children's therapeutic services and supports under section 256B.0943; and

85.21 (4) certified community behavioral health clinics under section 256B.0625, subdivision
85.22 5m.

85.23 (g) The commissioner must disenroll a provider listed in paragraph (f) from medical
85.24 assistance if:

85.25 (1) the provider's licensing application has been denied or the license has been suspended
85.26 or revoked; and

85.27 (2) the provider appealed the application denial or the license suspension or revocation,
85.28 and the commissioner issued a final order on the appeal affirming the action.

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

86.1 Sec. 4. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 3, is amended
86.2 to read:

86.3 Subd. 3. **Application fee for initial license or certification.** (a) Except as provided in
86.4 paragraphs (c) ~~and~~, (d), and (f), for fees required under subdivision 1, an applicant for an
86.5 initial license or certification issued by the commissioner shall submit a $2,100 application
86.6 fee with each new application required under this subdivision. The application fee shall not
86.7 be prorated, is nonrefundable, and is in lieu of the annual license or certification fee that
86.8 expires on December 31. The commissioner shall not process an application until the
86.9 application fee is paid.

86.10 (b) Except as provided in paragraph (c), an applicant shall apply for a license to provide
86.11 services at a specific location.

86.12 (c) For a license to provide home and community-based services to persons with
86.13 disabilities or age 65 and older under chapter 245D, an applicant shall submit an application
86.14 to provide services statewide. For fees required under subdivision 1, an applicant for an
86.15 initial license issued by the commissioner to provide home and community-based services
86.16 under chapter 245D shall submit a $4,200 application fee with each new application.

86.17 (d) For fees required under subdivision 1, an applicant for an initial license or certification
86.18 issued by the commissioner for children's residential facility ~~or mental health clinic licensure~~
86.19 ~~or certification~~ shall submit a $500 application fee with each new application required under
86.20 this subdivision.

86.21 (e) For fees required under subdivision 1, an applicant for an initial mental health clinic
86.22 certification issued by the commissioner shall submit a $2,100 application fee with each
86.23 new application required under this subdivision.

86.24 (f) For fees required under subdivision 1, an applicant for an initial license issued by
86.25 the commissioner to provide services at a certified community behavioral health clinic under
86.26 section 245I.17 shall submit a $4,200 application fee with each new application.

86.27 Sec. 5. Minnesota Statutes 2025 Supplement, section 245A.10, subdivision 4, is amended
86.28 to read:

86.29 Subd. 4. **License or certification fee for certain programs.** (a)(1) A program licensed
86.30 to provide one or more of the home and community-based services and supports identified
86.31 under chapter 245D to persons with disabilities or age 65 and older, shall pay an annual
86.32 nonrefundable license fee based on revenues derived from the provision of services that

87.1 would require licensure under chapter 245D during the calendar year immediately preceding
87.2 the year in which the license fee is paid, according to the following schedule:

	License Holder Annual Revenue	License Fee
87.3	License Holder Annual Revenue	License Fee
87.4	less than or equal to $10,000	$250
87.5 87.6	greater than $10,000 but less than or equal to $25,000	$375
87.7 87.8	greater than $25,000 but less than or equal to $50,000	$500
87.9 87.10	greater than $50,000 but less than or equal to $100,000	$625
87.11 87.12	greater than $100,000 but less than or equal to $150,000	$750
87.13 87.14	greater than $150,000 but less than or equal to $200,000	$1,000
87.15 87.16	greater than $200,000 but less than or equal to $250,000	$1,250
87.17 87.18	greater than $250,000 but less than or equal to $300,000	$1,500
87.19 87.20	greater than $300,000 but less than or equal to $350,000	$1,750
87.21 87.22	greater than $350,000 but less than or equal to $400,000	$2,000
87.23 87.24	greater than $400,000 but less than or equal to $450,000	$2,250
87.25 87.26	greater than $450,000 but less than or equal to $500,000	$2,500
87.27 87.28	greater than $500,000 but less than or equal to $600,000	$2,850
87.29 87.30	greater than $600,000 but less than or equal to $700,000	$3,200
87.31 87.32	greater than $700,000 but less than or equal to $800,000	$3,600
87.33 87.34	greater than $800,000 but less than or equal to $900,000	$3,900
87.35 87.36	greater than $900,000 but less than or equal to $1,000,000	$4,250
87.37 87.38	greater than $1,000,000 but less than or equal to $1,250,000	$4,550
87.39 87.40	greater than $1,250,000 but less than or equal to $1,500,000	$4,900
87.41 87.42	greater than $1,500,000 but less than or equal to $1,750,000	$5,200
87.43 87.44	greater than $1,750,000 but less than or equal to $2,000,000	$5,500

88.1 greater than $2,000,000 but less than or 88.2 equal to $2,500,000	$5,900
88.3 greater than $2,500,000 but less than or 88.4 equal to $3,000,000	$6,200
88.5 greater than $3,000,000 but less than or 88.6 equal to $3,500,000	$6,500
88.7 greater than $3,500,000 but less than or 88.8 equal to $4,000,000	$7,200
88.9 greater than $4,000,000 but less than or 88.10 equal to $4,500,000	$7,800
88.11 greater than $4,500,000 but less than or 88.12 equal to $5,000,000	$9,000
88.13 greater than $5,000,000 but less than or 88.14 equal to $7,500,000	$10,000
88.15 greater than $7,500,000 but less than or 88.16 equal to $10,000,000	$14,000
88.17 greater than $10,000,000 but less than or 88.18 equal to $12,500,000	$18,000
88.19 greater than $12,500,000 but less than or 88.20 equal to $15,000,000	$25,000
88.21 greater than $15,000,000 but less than or 88.22 equal to $17,500,000	$28,000
88.23 greater than $17,500,000 but less than 88.24 $20,000,000	$32,000
88.25 greater than $20,000,000 but less than 88.26 $25,000,000	$36,000
88.27 greater than $25,000,000 but less than 88.28 $30,000,000	$45,000
88.29 greater than $30,000,000 but less than 88.30 $35,000,000	$55,000
88.31 greater than $35,000,000	$75,000

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

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

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

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

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

89.11 (c) A detoxification program licensed under Minnesota Rules, parts 9530.6510 to
89.12 9530.6590, or a withdrawal management program licensed under chapter 245F shall pay
89.13 an annual nonrefundable license fee based on the following schedule:

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

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

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

Licensed Capacity	License Fee
1 to 24 persons	$1,000
25 to 49 persons	$1,100
50 to 74 persons	$1,200
75 to 99 persons	$1,300
100 or more persons	$1,400

89.29 (e) A residential facility licensed under section 245I.23 or Minnesota Rules, parts
89.30 9520.0500 to 9520.0670, to serve persons with mental illness shall pay an annual
89.31 nonrefundable license fee based on the following schedule:

Licensed Capacity	License Fee
1 to 24 persons	$2,600

90.1	25 to 49 persons	$3,000
90.2	50 or more persons	$20,000

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

	Licensed Capacity	License Fee
90.7	1 to 24 persons	$450
90.8	25 to 49 persons	$650
90.9	50 to 74 persons	$850
90.10	75 to 99 persons	$1,050
90.11	100 or more persons	$1,250

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

	Licensed Capacity	License Fee
90.16	1 to 24 persons	$2,600
90.17	25 to 49 persons	$3,000
90.18	50 to 74 persons	$5,000
90.19	75 to 99 persons	$10,000
90.20	100 to 199 persons	$15,000
90.21	200 or more persons	$20,000

90.22 (h) A program licensed to provide treatment services to persons with sexual psychopathic
90.23 personalities or sexually dangerous persons under Minnesota Rules, parts 9515.3000 to
90.24 9515.3110, shall pay an annual nonrefundable license fee of $20,000.

90.25 (i) A mental health clinic certified under section 245I.20 shall pay an annual
90.26 nonrefundable certification fee of ~~$1,550~~ $3,000. If the mental health clinic provides services
90.27 at a primary location with satellite facilities, the satellite facilities shall be certified with the
90.28 primary location without an additional charge.

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

91.1 (j) A program licensed to provide behavioral health treatment services licensed under
91.2 section 245I.22, 245I.24, 245I.30, or 245I.31 shall pay an annual nonrefundable license fee
91.3 of $3,000 for each license.

91.4 (k) Certified community behavioral health clinics licensed under section 245I.17 shall
91.5 pay an annual nonrefundable license fee of $7,800.

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

91.8 Subd. 4a. **Fees for satellite locations.** (a) If a program subject to annual fees under
91.9 subdivision 4, paragraph (b), provides services at a primary location with satellite facilities,
91.10 the satellite facilities are licensed with the primary location and are subject to an additional
91.11 $500 annual nonrefundable license fee per satellite facility.

91.12 (b) If a program subject to annual fees under subdivision 4, paragraph (j), provides
91.13 services at a primary location with satellite sites or facilities, the satellite locations must be
91.14 licensed with the primary location and are subject to an additional annual nonrefundable
91.15 fee according to the following schedule:

91.16 (1) one to five satellite locations: $1,500;

91.17 (2) six to 19 satellite locations: $3,500; or

91.18 (3) 20 or more satellite locations: $5,000.

91.19 Sec. 7. Minnesota Statutes 2024, section 245A.65, subdivision 1a, is amended to read:

91.20 Subd. 1a. **Determination of vulnerable adult status.** (a) A license holder that provides
91.21 services to adults who are excluded from the definition of vulnerable adult under section
91.22 626.5572, subdivision 21, paragraph (a), clause (2), must determine whether the person is
91.23 a vulnerable adult under section 626.5572, subdivision 21, paragraph (a), clause (4). This
91.24 determination must be made within 24 hours of:

91.25 (1) admission to the licensed program; and

91.26 (2) any incident that:

91.27 (i) was reported under section 626.557; or

91.28 (ii) would have been required to be reported under section 626.557, if one or more of
91.29 the adults involved in the incident had been vulnerable adults.

92.1 (b) Upon determining that a person receiving services is a vulnerable adult under section
92.2 626.5572, subdivision 21, paragraph (a), clause (4), all requirements relative to vulnerable
92.3 adults under this chapter and section 626.557 must be met by the license holder.

92.4 (c) Notwithstanding paragraph (a), clause (1), a license holder providing mobile crisis
92.5 services must make the required determination within 24 hours of first providing crisis
92.6 stabilization services to an adult under section 245I.24, subdivision 9.

92.7 Sec. 8. Minnesota Statutes 2024, section 245C.03, subdivision 1, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

93.3 (1) adult foster care;

93.4 (2) children's residential facilities;

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

93.6 (4) residential mental health programs for adults;

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

93.8 (6) withdrawal management programs under chapter 245F;

93.9 (7) adult day care centers;

93.10 (8) family adult day services;

93.11 (9) detoxification programs;

93.12 (10) community residential settings;

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

93.15 (12) treatment programs for persons with sexual psychopathic personality or sexually
93.16 dangerous persons, licensed under chapter 245A and according to Minnesota Rules, parts
93.17 9515.3000 to 9515.3110~~.~~;

93.18 (13) adult rehabilitative mental health services under chapter 245I;

93.19 (14) certified community behavioral health clinic services under chapter 245I;

93.20 (15) children's therapeutic services and supports under chapter 245I; and

93.21 (16) crisis response services under chapter 245I.

93.22 Sec. 9. Minnesota Statutes 2025 Supplement, section 245C.13, subdivision 2, is amended
93.23 to read:

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

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

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

93.29 (i) the individual is not disqualified; or

94.1 (ii) more time is needed to complete the study but the individual is not required to be
94.2 removed from direct contact or access to people receiving services prior to completion of
94.3 the study as provided under section 245C.17, subdivision 1, paragraph (b) or (c). The notice
94.4 that more time is needed to complete the study must also indicate whether the individual is
94.5 required to be under continuous direct supervision prior to completion of the background
94.6 study. When more time is necessary to complete a background study of an individual
94.7 affiliated with a Title IV-E eligible children's residential facility or foster residence setting,
94.8 the individual may not work in the facility or setting regardless of whether or not the
94.9 individual is supervised;

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

94.11 (3) a notice that a variance has been granted related to the individual under section
94.12 245C.30.

94.13 (b) For a background study affiliated with a licensed child care center or certified
94.14 license-exempt child care center, the notice sent under paragraph (a), clause (1), item (ii),
94.15 must not be issued until the commissioner receives a qualifying result for the individual for
94.16 the fingerprint-based national criminal history record check or the fingerprint-based criminal
94.17 history information from the Bureau of Criminal Apprehension. The notice must require
94.18 the individual to be under continuous direct supervision prior to completion of the remainder
94.19 of the background study except as permitted in subdivision 3.

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

94.21 (1) being issued a license;

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

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

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

94.28 (5) for licensed child care centers and certified license-exempt child care centers,
94.29 providing direct contact services to persons served by the program;

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

(7) for background studies affiliated with a personal care provider organization, except as provided in section 245C.03, subdivision 3b, or with an early intensive developmental and behavioral intervention provider or adult rehabilitative mental health services provider, before ~~a personal care assistant~~ an individual provides services, the ~~personal care assistance provider agency~~ entity must initiate a background study of the ~~personal care assistant~~ individual under this chapter and the ~~personal care assistance provider agency~~ entity must have received a notice from the commissioner that the ~~personal care assistant~~ individual is:

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

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

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

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

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

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

Subdivision 1. **License requirements.** (a) An applicant for a license to provide substance use disorder treatment must comply with the general requirements in section 626.557; chapters 245A, 245C, and 260E; and Minnesota Rules, chapter 9544.

(b) The commissioner may grant variances to the requirements in this chapter that do not affect the client's health or safety if the conditions in section 245A.04, subdivision 9, are met.

(c) If a program is licensed according to this chapter and is part of a certified community behavioral health clinic under section ~~245.735~~ 245I.17, the license holder must comply with the requirements in section ~~245.735~~ 245I.17, subdivisions ~~4b to 4e~~ 12 and 13, as part of the licensing requirements under this chapter.

Sec. 11. Minnesota Statutes 2024, section 245I.011, subdivision 3, is amended to read:

Subd. 3. **Certification required.** (a) An individual, organization, or government entity that is exempt from licensure under section 245A.03, subdivision 2, paragraph (a), clause ~~(12)~~ (15), and chooses to be identified as a certified mental health clinic must:

(1) be a mental health clinic that is certified under section 245I.20;

(2) comply with all of the responsibilities assigned to a license holder by this chapter except subdivision 1; and

(3) comply with all of the responsibilities assigned to a certification holder by chapter 245A.

(b) An individual, organization, or government entity described by this subdivision must obtain a criminal background study for each staff person or volunteer who provides direct contact services to clients.

~~(c) If a clinic is certified according to this chapter and is part of a certified community behavioral health clinic under section 245.735, the license holder must comply with the requirements in section 245.735, subdivisions 4b to 4e, as part of the licensing requirements under this chapter.~~

EFFECTIVE DATE. This section is effective the day following final enactment, except the amendment striking paragraph (c) is effective January 1, 2028.

Sec. 12. Minnesota Statutes 2024, section 245I.011, subdivision 5, is amended to read:

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

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

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

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

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

~~(5)~~ (2) a children's intensive behavioral health services provider under section 256B.0946; and

~~(6)~~ (3) an intensive nonresidential rehabilitative mental health services provider under section 256B.0947.

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

97.4 **EFFECTIVE DATE.** This section is effective January 1, 2028.

97.5 Sec. 13. Minnesota Statutes 2024, section 245I.011, is amended by adding a subdivision
97.6 to read:

97.7 Subd. 6. **License required for nonresidential programs.** (a) Beginning January 1,
97.8 2028, an individual, organization, or government entity must have a license under this
97.9 chapter to provide the following services:

97.10 (1) adult rehabilitative mental health services, as defined in section 256B.0623;

97.11 (2) mobile crisis services, as defined in section 256B.0624;

97.12 (3) children's therapeutic services and supports, as defined in section 256B.0943; or

97.13 (4) certified community behavioral health clinic services, as defined in sections 245I.17
97.14 and 256B.0625, subdivision 5m.

97.15 (b) An individual, organization, or government entity certified as any of the following
97.16 must remain certified according to subdivision 5 until the commissioner issues a license,
97.17 the commissioner denies the license application, or the certification expires according to
97.18 chapter 245A:

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

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

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

97.22 (4) a certified community behavioral health clinic under section 245.735.

97.23 Sec. 14. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
97.24 to read:

97.25 Subd. 1a. **Alcohol and drug counselor** "Alcohol and drug counselor" means an individual
97.26 qualified under section 245G.11, subdivision 5.

98.1 Sec. 15. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
98.2 to read:

98.3 Subd. 10a. **Comprehensive evaluation.** "Comprehensive evaluation" means a
98.4 person-centered, family-centered, and trauma-informed evaluation conducted according to
98.5 section 245I.17, subdivision 12.

98.6 Sec. 16. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
98.7 to read:

98.8 Subd. 18a. **Initial evaluation.** "Initial evaluation" means the assessment and preliminary
98.9 diagnosis necessary to begin client services, conducted according to section 245I.17.

98.10 Sec. 17. Minnesota Statutes 2024, section 245I.02, is amended by adding a subdivision
98.11 to read:

98.12 Subd. 31a. **Psychotherapy.** "Psychotherapy" has the meaning given in section 256B.0671,
98.13 subdivision 11.

98.14 Sec. 18. Minnesota Statutes 2024, section 245I.02, subdivision 33, is amended to read:

98.15 Subd. 33. **Rehabilitative mental health services.** "Rehabilitative mental health services"
98.16 means mental health services provided to ~~an adult~~ a client that enable the client to develop
98.17 and achieve psychiatric stability, social competencies, personal and emotional adjustment,
98.18 independent living skills, family roles, and community skills when symptoms of mental
98.19 illness has impaired any of the client's abilities in these areas. Rehabilitative mental health
98.20 services include interventions that allow a client to self-monitor, compensate for, counteract,
98.21 or replace psychosocial skills deficits or maladaptive skills acquired over the course of a
98.22 mental illness. For a child client, rehabilitative mental health services include interventions
98.23 to restore a child or adolescent to an age-appropriate developmental trajectory that has been
98.24 disrupted by a mental illness.

98.25 Sec. 19. Minnesota Statutes 2024, section 245I.02, subdivision 39, is amended to read:

98.26 Subd. 39. **Treatment plan.** "Treatment plan" means services that a license holder
98.27 formulates to respond to a client's needs and goals. A treatment plan includes individual
98.28 treatment plans under section 245I.10, subdivisions 7 and 8; initial treatment plans under
98.29 section 245I.23, subdivision 7; and crisis treatment plans under sections 245I.23, subdivision
98.30 8, and 256B.0624, subdivision 11. For a license holder under section 245I.17, a treatment

99.1 plan is the integrated treatment plan developed according to section 245I.17, subdivision
99.2 13.

99.3 Sec. 20. Minnesota Statutes 2024, section 245I.03, subdivision 4, is amended to read:

99.4 Subd. 4. **Behavioral emergencies.** (a) A license holder must have procedures that each
99.5 staff person follows when responding to a client who exhibits behavior that threatens the
99.6 immediate safety of the client or others. A license holder's behavioral emergency procedures
99.7 must incorporate person-centered planning and trauma-informed care.

99.8 (b) A license holder's behavioral emergency procedures must include:

99.9 (1) a plan designed to prevent the client from inflicting self-harm and harming others;

99.10 (2) contact information for emergency resources that a staff person must use when the
99.11 license holder's behavioral emergency procedures are unsuccessful in controlling a client's
99.12 behavior;

99.13 (3) the types of behavioral emergency procedures that a staff person may use;

99.14 (4) the specific circumstances under which the program may use behavioral emergency
99.15 procedures; ~~and~~

99.16 (5) the staff persons whom the license holder authorizes to implement behavioral
99.17 emergency procedures~~.~~; and

99.18 (6) the contact information for the local crisis team.

99.19 (c) The license holder's behavioral emergency procedures must not include secluding
99.20 or restraining a client except as allowed under section 245.8261.

99.21 (d) Staff persons must not use behavioral emergency procedures to enforce program
99.22 rules or for the convenience of staff persons. Behavioral emergency procedures must not
99.23 be part of any client's treatment plan. A staff person may not use behavioral emergency
99.24 procedures except in response to a client's current behavior that threatens the immediate
99.25 safety of the client or others.

99.26 Sec. 21. Minnesota Statutes 2024, section 245I.03, is amended by adding a subdivision
99.27 to read:

99.28 Subd. 11. **Quality assurance and improvement plan.** (a) At a minimum, a license
99.29 holder must develop a written quality assurance and improvement plan that includes plans
99.30 for:

100.1 (1) encouraging ongoing consultation among members of the treatment team;

100.2 (2) obtaining and evaluating feedback about services from clients, family and other
100.3 natural supports, referral sources, and staff persons;

100.4 (3) measuring and evaluating client outcomes;

100.5 (4) reviewing client suicide deaths and suicide attempts;

100.6 (5) examining the quality of clinical service delivery to clients; and

100.7 (6) self-monitoring of compliance with this chapter.

100.8 (b) At least annually, a license holder must review, evaluate, and update the quality
100.9 assurance and improvement plan. The review must:

100.10 (1) include documentation of the actions that the certification holder will take as a result
100.11 of information obtained from monitoring activities in the plan; and

100.12 (2) establish goals for improved service delivery to clients for the next year.

100.13 Sec. 22. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 5, is amended
100.14 to read:

100.15 Subd. 5. **Behavioral health practitioner scope of practice.** (a) A behavioral health
100.16 practitioner under the treatment supervision of a mental health professional or certified
100.17 rehabilitation specialist may provide an adult client with client education, rehabilitative
100.18 mental health services, functional assessments, level of care assessments, crisis planning,
100.19 and treatment plans. A behavioral health practitioner under the treatment supervision of a
100.20 mental health professional may provide skill-building services ~~to a child client~~, crisis
100.21 planning, and complete treatment plans for a child client.

100.22 (b) A behavioral health practitioner must not provide treatment supervision to other staff
100.23 persons. A behavioral health practitioner may provide direction to mental health rehabilitation
100.24 workers and mental health behavioral aides.

100.25 (c) A behavioral health practitioner who provides services to clients according to section
100.26 256B.0624 may perform crisis assessments and interventions for a client.

100.27 Sec. 23. Minnesota Statutes 2025 Supplement, section 245I.04, subdivision 17, is amended
100.28 to read:

100.29 Subd. 17. **Mental health behavioral aide scope of practice.** While under the treatment
100.30 supervision of a mental health professional, a mental health behavioral aide may ~~practice~~

~~psychosocial skills with~~ provide skill-building services to a child client ~~according to the child's treatment plan and individual behavior plan that a mental health professional, clinical trainee, or behavioral health practitioner has previously taught to the child~~.

Sec. 24. Minnesota Statutes 2024, section 245I.06, subdivision 1, is amended to read:

Subdivision 1. **Generally.** (a) A license holder must ensure that a mental health professional or certified rehabilitation specialist provides treatment supervision to each staff person who provides services to a client and who is not a mental health professional or certified rehabilitation specialist. When providing treatment supervision, a treatment supervisor must follow a staff person's written treatment supervision plan.

(b) Treatment supervision must focus on each client's treatment needs and the ability of the staff person under treatment supervision to provide services to each client, including the following topics related to the staff person's current caseload:

(1) a review and evaluation of the interventions that the staff person delivers to each client;

(2) instruction on alternative strategies if a client is not achieving treatment goals;

(3) a review and evaluation of each client's assessments, treatment plans, and progress notes for accuracy and appropriateness;

(4) instruction on the cultural norms or values of the clients and communities that the license holder serves and the impact that a client's culture has on providing treatment;

(5) evaluation of and feedback regarding a direct service staff person's areas of competency; ~~and~~

(6) coaching, teaching, and practicing skills with a staff person~~.~~; and

(7) modeling service practices that respect the client, include the client in planning and implementation of the individual treatment plan, recognize the client's strengths, and coordinate with other involved parties and providers.

(c) A treatment supervisor must provide treatment supervision to a staff person using methods that allow for immediate feedback, including in-person, telephone, and interactive video supervision.

(d) A treatment supervisor's responsibility for a staff person receiving treatment supervision is limited to the services provided by the associated license holder. If a staff person receiving treatment supervision is employed by multiple license holders, each license

102.1 holder is responsible for providing treatment supervision related to the treatment of the
102.2 license holder's clients.

102.3 Sec. 25. Minnesota Statutes 2024, section 245I.06, subdivision 2, is amended to read:

102.4 Subd. 2. **Treatment supervision planning.** (a) A treatment supervisor and the staff
102.5 person supervised by the treatment supervisor must develop a written treatment supervision
102.6 plan. The license holder must ensure that a new staff person's treatment supervision plan is
102.7 completed, approved by the staff person, and implemented by a treatment supervisor and
102.8 the new staff person within 30 days of the new staff person's first day of employment. The
102.9 license holder must review and update each staff person's treatment supervision plan annually.

102.10 (b) Each staff person's treatment supervision plan must include:

102.11 (1) the name and qualifications of the staff person receiving treatment supervision;

102.12 (2) the names and licensures of the treatment supervisors who are supervising the staff
102.13 person;

102.14 (3) how frequently the treatment supervisors must provide treatment supervision to the
102.15 staff person; and

102.16 (4) the staff person's authorized scope of practice, including a description of the client
102.17 ~~population~~ ages that the staff person serves, and a description of the treatment methods and
102.18 modalities that the staff person may use to provide services to clients.

102.19 Sec. 26. Minnesota Statutes 2024, section 245I.07, is amended to read:

102.20 **245I.07 PERSONNEL FILES.**

102.21 (a) For each staff person, a license holder must maintain a personnel file that includes:

102.22 (1) verification of the staff person's qualifications required for the position including
102.23 training, education, practicum or internship agreement, licensure, and any other required
102.24 qualifications;

102.25 (2) documentation related to the staff person's background study;

102.26 (3) the hiring date of the staff person;

102.27 (4) a description of the staff person's job responsibilities with the license holder;

102.28 (5) the date that the staff person's specific duties and responsibilities became effective,
102.29 including the date that the staff person began having direct contact with clients;

103.1 (6) documentation of the staff person's training as required by section 245I.05, subdivision
103.2 2;

103.3 (7) a verification copy of license renewals that the staff person completed during the
103.4 staff person's employment;

103.5 (8) annual job performance evaluations; and

103.6 (9) if applicable, the staff person's alleged and substantiated violations of the license
103.7 holder's policies under section 245I.03, subdivision 8, clauses (3) to (7), and the license
103.8 holder's response.

103.9 (b) The license holder must ensure that all personnel files are readily accessible for the
103.10 commissioner's review. The license holder is not required to keep personnel files in a single
103.11 location.

103.12 (c) For a license holder under section 245I.17, a personnel file for staff who provide
103.13 substance use disorder treatment services must include records of training required under
103.14 section 245G.13, subdivision 2.

103.15 Sec. 27. Minnesota Statutes 2024, section 245I.10, is amended by adding a subdivision
103.16 to read:

103.17 Subd. 2a. **Evaluation, treatment authorization, and planning in a certified community**
103.18 **behavioral health clinic.** Notwithstanding subdivisions 2 and 7, a license holder under
103.19 section 245I.17 must meet the requirements for assessments under section 245I.17,
103.20 subdivisions 11 and 12, and for treatment planning under section 245I.17, subdivision 13.
103.21 Certified community behavioral health clinic service planning and authorization must comply
103.22 with the standards in section 245I.17.

103.23 Sec. 28. Minnesota Statutes 2024, section 245I.10, subdivision 6, is amended to read:

103.24 Subd. 6. **Standard diagnostic assessment; required elements.** (a) Only a mental health
103.25 professional or a clinical trainee may complete a standard diagnostic assessment of a client.
103.26 A standard diagnostic assessment of a client must include a face-to-face interview with a
103.27 client and a written evaluation of the client. The assessor must complete a client's standard
103.28 diagnostic assessment within the client's cultural context. An alcohol and drug counselor
103.29 may gather and document the information in paragraphs (b) and (c) when completing a
103.30 comprehensive assessment according to section 245G.05.

104.1 (b) When completing a standard diagnostic assessment of a client, the assessor must
104.2 gather and document information about the client's current life situation, including the
104.3 following information:

104.4 (1) the client's age;

104.5 (2) the client's current living situation, including the client's housing status and household
104.6 members;

104.7 (3) the status of the client's basic needs;

104.8 (4) the client's education level and employment status;

104.9 (5) the client's current medications;

104.10 (6) any immediate risks to the client's health and safety, including withdrawal symptoms,
104.11 medical conditions, and behavioral and emotional symptoms;

104.12 (7) the client's perceptions of the client's condition;

104.13 (8) the client's description of the client's symptoms, including the reason for the client's
104.14 referral;

104.15 (9) the client's history of mental health and substance use disorder treatment;

104.16 (10) cultural influences on the client; and

104.17 (11) substance use history, if applicable, including:

104.18 (i) amounts and types of substances, frequency and duration, route of administration,
104.19 periods of abstinence, and circumstances of relapse; and

104.20 (ii) the impact to functioning when under the influence of substances, including legal
104.21 interventions.

104.22 (c) If the assessor cannot obtain the information that this paragraph requires without
104.23 retraumatizing the client or harming the client's willingness to engage in treatment, the
104.24 assessor must identify which topics will require further assessment during the course of the
104.25 client's treatment. The assessor must gather and document information related to the following
104.26 topics:

104.27 (1) the client's relationship with the client's family and other significant personal
104.28 relationships, including the client's evaluation of the quality of each relationship;

104.29 (2) the client's strengths and resources, including the extent and quality of the client's
104.30 social networks;

105.1 (3) important developmental incidents in the client's life;

105.2 (4) maltreatment, trauma, potential brain injuries, and abuse that the client has suffered;

105.3 (5) the client's history of or exposure to alcohol and drug usage and treatment; and

105.4 (6) the client's health history and the client's family health history, including the client's
105.5 physical, chemical, and mental health history.

105.6 (d) When completing a standard diagnostic assessment of a client, an assessor must use
105.7 a recognized diagnostic framework.

105.8 (1) When completing a standard diagnostic assessment of a client who is five years of
105.9 age or younger, the assessor must use the current edition of the DC: 0-5 Diagnostic
105.10 Classification of Mental Health and Development Disorders of Infancy and Early Childhood
105.11 published by Zero to Three.

105.12 (2) When completing a standard diagnostic assessment of a client who is six years of
105.13 age or older, the assessor must use the current edition of the Diagnostic and Statistical
105.14 Manual of Mental Disorders published by the American Psychiatric Association.

105.15 (3) When completing a standard diagnostic assessment of a client who is 12 to 17 years
105.16 of age, an assessor must use either the CRAFFT Questionnaire or the criteria in the most
105.17 recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by
105.18 the American Psychiatric Association to screen and assess the client for a substance use
105.19 disorder.

105.20 ~~(3)~~ (4) When completing a standard diagnostic assessment of a client who is 18 years
105.21 of age or older, an assessor must use either (i) the CAGE-AID Questionnaire or (ii) the
105.22 criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental
105.23 Disorders published by the American Psychiatric Association to screen and assess the client
105.24 for a substance use disorder.

105.25 (e) When completing a standard diagnostic assessment of a client, the assessor must
105.26 include and document the following components of the assessment:

105.27 (1) the client's mental status examination;

105.28 (2) the client's baseline measurements; symptoms; behavior; skills; abilities; resources;
105.29 vulnerabilities; safety needs, including client information that supports the assessor's findings
105.30 after applying a recognized diagnostic framework from paragraph (d); and any differential
105.31 diagnosis of the client; and

106.1 (3) an explanation of: (i) how the assessor diagnosed the client using the information
106.2 from the client's interview, assessment, psychological testing, and collateral information
106.3 about the client; (ii) the client's needs; (iii) the client's risk factors; (iv) the client's strengths;
106.4 and (v) the client's responsivity factors.

106.5 (f) When completing a standard diagnostic assessment of a client, the assessor must
106.6 consult the client and the client's family about which services that the client and the family
106.7 prefer to treat the client. ~~The assessor must make referrals for the client as to services required~~
106.8 ~~by law.~~

106.9 (g) Information from other providers and prior assessments may be used to complete
106.10 the diagnostic assessment if the source of the information is documented in the diagnostic
106.11 assessment.

106.12 (h) If the client screens positive for a need for substance use disorder treatment services,
106.13 the assessor must document what actions will be taken to address the client's co-occurring
106.14 conditions.

106.15 (i) The assessor must determine if the client is eligible for targeted case management
106.16 services according to section 245.462, subdivision 20, or 245.4871, subdivision 6, and refer
106.17 the client to the county or contracted provider as appropriate.

106.18 Sec. 29. Minnesota Statutes 2024, section 245I.10, subdivision 8, is amended to read:

106.19 Subd. 8. **Individual treatment plan; required elements.** (a) After completing a client's
106.20 diagnostic assessment or reviewing a client's diagnostic assessment received from a different
106.21 provider and before providing services to the client beyond those permitted under subdivision
106.22 7, the license holder must complete the client's individual treatment plan. The license holder
106.23 must:

106.24 (1) base the client's individual treatment plan on the client's diagnostic assessment and
106.25 baseline measurements;

106.26 (2) for a child client, use a child-centered, family-driven, and culturally appropriate
106.27 planning process that allows the child's parents and guardians to observe and participate in
106.28 the child's individual and family treatment services, assessments, and treatment planning;

106.29 (3) for an adult client, use a person-centered, culturally appropriate planning process
106.30 that allows the client's family and other natural supports to observe and participate in the
106.31 client's treatment services, assessments, and treatment planning;

107.1 (4) identify the client's treatment goals, measureable treatment objectives, a schedule
107.2 for accomplishing the client's treatment goals and objectives, a treatment strategy, and the
107.3 individuals responsible for providing treatment services and supports to the client. The
107.4 license holder must have a treatment strategy to engage the client in treatment if the client:

107.5 (i) has a history of not engaging in treatment; and

107.6 (ii) is ordered by a court to participate in treatment services or to take neuroleptic
107.7 medications;

107.8 (5) identify the participants involved in the client's treatment planning. The client must
107.9 be a participant in the client's treatment planning. If applicable, the license holder must
107.10 document the reasons that the license holder did not involve the client's family<u>, case manager,</u>
107.11 or other natural supports in the client's treatment planning;<u> and</u>

107.12 ~~(6) review the client's individual treatment plan every 180 days and update the client's~~
107.13 ~~individual treatment plan with the client's treatment progress, new treatment objectives and~~
107.14 ~~goals or, if the client has not made treatment progress, changes in the license holder's~~
107.15 ~~approach to treatment; and~~

107.16 ~~(7)~~<u> (6)</u> ensure that the client approves of the client's individual treatment plan unless a
107.17 court orders the client's treatment plan under chapter 253B.

107.18 (b) If the client disagrees with the client's treatment plan, the license holder must
107.19 document in the client file the reasons why the client does not agree with the treatment plan.
107.20 If the license holder cannot obtain the client's approval of the treatment plan, a mental health
107.21 professional must make efforts to obtain approval from a person who is authorized to consent
107.22 on the client's behalf within 30 days after the client's previous individual treatment plan
107.23 expired. A license holder may not deny a client service during this time period solely because
107.24 the license holder could not obtain the client's approval of the client's individual treatment
107.25 plan. A license holder may continue to bill for the client's otherwise eligible services when
107.26 the client re-engages in services.

107.27 <u>(c) The individual treatment plan must be updated as necessary to reflect the changing</u>
107.28 <u>needs of the client. The individual treatment plan must provide assistance with accessing</u>
107.29 <u>necessary crisis services when the license holder is aware of the client's need for crisis</u>
107.30 <u>services. The license holder must review the client's individual treatment plan every 180</u>
107.31 <u>days and update the client's individual treatment plan with the client's treatment progress,</u>
107.32 <u>new treatment objectives and goals, or, if the client has not made treatment progress, changes</u>
107.33 <u>in the license holder's approach to treatment.</u>

108.1 Sec. 30. **[245I.17] CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINIC**
108.2 **LICENSURE.**

108.3 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms in this
108.4 subdivision have the meanings given.

108.5 (b) "Care coordination" means the activities required to coordinate care across settings
108.6 and providers for an individual served to ensure seamless transitions across the full spectrum
108.7 of health services. Care coordination includes:

108.8 (1) outreach and engagement;

108.9 (2) documenting a plan of care for medical, behavioral health, and social services and
108.10 supports in the integrated treatment plan;

108.11 (3) assisting with obtaining appointments;

108.12 (4) confirming appointments are kept;

108.13 (5) developing a crisis plan;

108.14 (6) tracking medication; and

108.15 (7) implementing care coordination agreements with external providers. Care coordination
108.16 may include psychiatric consultation with primary care practitioners and with mental health
108.17 clinical care practitioners.

108.18 (c) "CCBHC client" means an individual who has participated in a preliminary screening
108.19 and risk assessment and who has received at least one of the nine required services from a
108.20 CCBHC.

108.21 (d) "Certified community behavioral health clinic" or "CCBHC" means a provider of
108.22 integrated behavioral health services that is licensed under this section and compliant with
108.23 federal CCBHC requirements.

108.24 (e) "Community needs assessment" means an assessment to identify community needs
108.25 and determine the community behavioral health clinic's capacity to address the needs of the
108.26 population being served.

108.27 (f) "Designated collaborating organization" means an entity meeting the requirements
108.28 of subdivision 5 that has a formal agreement with a CCBHC to furnish CCBHC services.

108.29 (g) "Federal CCBHC criteria" means the most recently issued Certified Community
108.30 Behavioral Health Clinic Certification Criteria published by the Substance Abuse and Mental
108.31 Health Services Administration.

109.1 (h) "Needs assessment" means the community needs assessment described in federal
109.2 criteria for CCBHC.

109.3 (i) "Preliminary screening and risk assessment" means a mandatory screening and risk
109.4 assessment that is completed at the time of first contact, whether that contact is in person,
109.5 by telephone, or using other remote communication.

109.6 Subd. 2. **Establishment of licensure.** (a) The certified community behavioral health
109.7 clinic model is an integrated service delivery model that uses evidence-based behavioral
109.8 health practices to achieve better outcomes for individuals experiencing behavioral health
109.9 concerns while achieving sustainable rates through cost-based reimbursement for providers
109.10 and economic efficiencies for payors.

109.11 (b) Beginning January 1, 2028, a CCBHC must be licensed under this section and chapter
109.12 245A.

109.13 (c) A CCBHC must meet the requirements of this section and federal CCBHC criteria.
109.14 The commissioner may require a CCBHC applicant or license holder to submit documentation
109.15 of compliance with state licensing requirements and federal CCBHC criteria. When permitted
109.16 by the Substance Abuse and Mental Health Services Administration, the commissioner may
109.17 select a transition date on which revisions to the federal CCBHC criteria become required
109.18 as licensing conditions for CCBHCs.

109.19 Subd. 3. **License extension.** (a) The commissioner must extend a compliant license
109.20 holder's license under this section for 36 months.

109.21 (b) The commissioner must complete a licensing review that includes an on-site inspection
109.22 within six months before the expiration of the CCBHC's current license.

109.23 (c) Within 180 days of license expiration, a CCBHC license holder must submit to the
109.24 commissioner all documentation required by the commissioner under subdivision 2,
109.25 paragraph (c).

109.26 Subd. 4. **Required services and scope of licensure.** Within a declared service area, the
109.27 CCBHC must be able to offer:

109.28 (1) mobile crisis services, directly or through a designated collaborating organization
109.29 under subdivision 4;

109.30 (2) outpatient mental health and substance use disorder treatment services under
109.31 subdivisions 9 and 10;

109.32 (3) screening, diagnosis, and risk assessment under subdivision 11;

110.1 (4) person- and family-centered treatment planning;

110.2 (5) psychiatric rehabilitation services under subdivision 14;

110.3 (6) community-based mental health care for veterans under subdivision 15;

110.4 (7) outpatient primary care screening and monitoring under subdivision 16;

110.5 (8) peer services under subdivision 17; and

110.6 (9) targeted case management under subdivision 18.

110.7 Subd. 5. **Designated collaborating organization.** (a) If a CCBHC is unable to provide
110.8 mobile crisis services, the CCBHC may contract with another entity that is licensed to
110.9 provide mobile crisis services under section 245I.24 and that meets the requirements of the
110.10 federal CCBHC criteria as a designated collaborating organization.

110.11 (b) The CCBHC must submit a designated collaborating organization arrangement for
110.12 approval to the commissioner as part of the licensing process.

110.13 Subd. 6. **Exemptions to host county approval.** Notwithstanding any other law that
110.14 requires a county contract or other form of county approval for a service listed in subdivision
110.15 4, a CCBHC that meets the requirements of this section may receive the prospective payment
110.16 under section 256B.0625, subdivision 5m, for that service without a county contract or
110.17 county approval.

110.18 Subd. 7. **Variances.** When the standards listed in this section or other applicable standards
110.19 conflict or address similar issues in duplicative or incompatible ways, the commissioner
110.20 may grant variances to state requirements if the variances do not conflict with federal
110.21 requirements for services reimbursed under medical assistance. If standards overlap, the
110.22 commissioner may substitute all or a part of a licensure or certification that is substantially
110.23 the same as another licensure or certification. The commissioner must consult with
110.24 stakeholders before granting variances under this provision. For a CCBHC that is licensed
110.25 but not approved for prospective payment under section 256B.0625, subdivision 5m, the
110.26 commissioner may grant a variance under this paragraph if the variance does not increase
110.27 the state share of costs.

110.28 Subd. 8. **Evidence-based practices.** The commissioner must issue a list of required
110.29 evidence-based practices to be delivered by CCBHCs and may also provide a list of
110.30 recommended evidence-based practices. The commissioner may update the list to reflect
110.31 advances in outcomes research and medical services for persons living with mental illnesses
110.32 or substance use disorders. When developing the list, the commissioner must consider the
110.33 adequacy of evidence to support the efficacy of the practice across cultures and ages, the

111.1 workforce available, and the current availability of the practices in the state. At least 30
111.2 days before issuing the initial list or issuing any revisions, the commissioner must provide
111.3 stakeholders with an opportunity to comment.

111.4 Subd. 9. **Outpatient mental health services.** (a) A license holder must provide outpatient
111.5 mental health services that comply with the federal CCBHC criteria and applicable state
111.6 standards in this chapter, except as provided in this subdivision.

111.7 (b) Completion of an initial or comprehensive evaluation fulfills the requirements to
111.8 perform a diagnostic assessment in accordance with section 245I.10, subdivisions 2 and 6.

111.9 (c) An integrated treatment plan under this section fulfills the requirements to conduct
111.10 treatment planning in accordance with section 245I.10, subdivisions 7 and 8.

111.11 (d) A license holder under this section is exempt from certification as a mental health
111.12 clinic under section 245I.20.

111.13 Subd. 10. **Outpatient substance use disorder treatment.** (a) When a license holder
111.14 provides substance use disorder treatment services to an individual with a substance use
111.15 disorder diagnosis, the license holder must comply with the requirements for substance use
111.16 disorder treatment services in chapter 245G, except as provided in this subdivision.

111.17 (b) Completion of a preliminary screening and risk assessment under this section fulfills
111.18 the requirements to complete an initial services plan under section 245G.04, subdivision 1.

111.19 (c) Completion of a comprehensive evaluation under this section fulfills the requirements
111.20 to administer a comprehensive assessment under section 245G.05.

111.21 (d) An integrated treatment plan under this section that contains a six-dimension analysis
111.22 of the client's needs according to the third edition of ASAM criteria, as defined in section
111.23 254B.01, subdivision 2a, fulfills the requirements to provide an individual treatment plan
111.24 under section 245G.06.

111.25 (e) A license holder under this section fulfills the requirement to document personnel
111.26 files under section 245G.13, subdivision 3, by complying with the requirements of this
111.27 chapter.

111.28 (f) A license holder under this section fulfills the requirement to protect client rights
111.29 under section 245G.15 by complying with the requirements of section 245I.12.

111.30 (g) A license holder under this section fulfills the requirements to respond to behavioral
111.31 emergencies under section 245G.16 by complying with the requirements of section 245I.03,
111.32 subdivision 4.

112.1 (h) A license holder under this section is exempt from licensure under chapter 245G.

112.2 Subd. 11. **Initial triage and risk assessment.** (a) A license holder must have policies
112.3 and procedures on:

112.4 (1) how staff will implement the requirements of this subdivision;

112.5 (2) staff positions authorized to complete triage and risk assessments;

112.6 (3) documenting the results of the risk screenings; and

112.7 (4) ensuring the client is offered timely services according to the federal CCBHC criteria.

112.8 (b) A license holder must conduct an initial triage and risk assessment when a new client
112.9 requests services or is referred to services. A license holder may conduct an initial triage
112.10 and risk assessment in person, by telephone, or through other remote communication. Based
112.11 on the acuity of needs as assessed in the initial triage and risk assessment, the client must
112.12 be categorized as having emergency, urgent, or routine needs.

112.13 (c) Based on these categorizations, the license holder must offer services that meet the
112.14 relevant timelines under the federal CCBHC criteria.

112.15 (d) The license holder must provide training that addresses:

112.16 (1) when a prospective client requires intervention from qualified staff;

112.17 (2) the use of standardized measures that screen for significant risks;

112.18 (3) other factors that indicate a client has urgent needs besides the Columbia Suicide
112.19 Severity Rating Scale or a self-harm screening; and

112.20 (4) overdose and substance use disorder risks.

112.21 Subd. 12. **Initial and comprehensive evaluation.** (a) A license holder under this section
112.22 must provide initial and comprehensive evaluations according to this section and federal
112.23 CCBHC criteria.

112.24 (b) An initial evaluation is necessary to authorize the provision of all medically necessary
112.25 CCBHC services until the completion of a comprehensive evaluation. A comprehensive
112.26 evaluation is necessary to authorize the provision of all medically necessary CCBHC services
112.27 on an ongoing basis. A license holder must ensure that each client's comprehensive evaluation
112.28 reflects the needs and assessments for all services provided.

112.29 Subd. 13. **Integrated treatment plan.** (a) A license holder under this section must
112.30 complete an integrated treatment plan for each client following the client's comprehensive
112.31 evaluation no later than 60 calendar days after the date of the first request for services.

113.1 (b) A license holder must document all required services under subdivision 9 within the
113.2 integrated treatment plan based on the client's needs.

113.3 (c) A license holder must review and update a client's integrated treatment plan as
113.4 necessary to reflect the changing needs of the client and progress made in treatment. If the
113.5 client has not made treatment progress, updates to the treatment plan must indicate changes
113.6 in the license holder's approach to treatment to better meet the needs of the client. A license
113.7 holder must review and update the integrated treatment plan at least every 180 days or as
113.8 clinically indicated.

113.9 Subd. 14. **Psychiatric rehabilitation services.** (a) For children, a license holder under
113.10 this section must provide children's therapeutic services and supports according to sections
113.11 245I.30 and 245I.31, except that an initial or comprehensive assessment under this section
113.12 fulfills the requirement to perform a standard diagnostic assessment.

113.13 (b) For adults, a license holder under this section must provide adult rehabilitative mental
113.14 health services according to section 245I.22, except that:

113.15 (1) the license holder is exempt from the requirement to perform a level of care
113.16 assessment under section 245I.22, subdivision 6, paragraph (b); and

113.17 (2) an initial or comprehensive assessment under this section fulfills the requirement to
113.18 perform a standard diagnostic assessment.

113.19 Subd. 15. **Community-based care for veterans.** (a) The license holder must provide
113.20 services according to federal requirements for eligibility and coordination with TRICARE
113.21 and the United States Department of Veterans Affairs.

113.22 (b) The license holder must assign and document a principal behavioral health provider
113.23 for every veteran receiving services.

113.24 Subd. 16. **Primary care screening and monitoring.** To fulfill the requirements for
113.25 primary care screening, a license holder under this section must have policies and procedures
113.26 detailing the screenings to be performed with specific populations at the clinic. The policies
113.27 and procedures must be approved by the medical director.

113.28 Subd. 17. **Peer services.** A license holder must be able to provide peer services as
113.29 described by federal CCBHC criteria and sections 245G.07, subdivision 2, clause (8),
113.30 256B.0615, and 256B.0616.

113.31 Subd. 18. **Targeted case management.** (a) A license holder must provide mental health
113.32 targeted case management as described by federal CCBHC criteria and section 256B.0625,
113.33 subdivision 20.

114.1 (b) An initial or comprehensive evaluation under this section fulfills any requirement
114.2 to perform a standard diagnostic assessment for targeted case management.

114.3 Subd. 19. **Community needs assessment.** (a) The community needs assessment must
114.4 be a collaborative document that reflects the license holder's or applicant's engagement with
114.5 current clients, other social and medical services agencies, community groups, underserved
114.6 populations, and government agencies. The applicant or license holder must document an
114.7 outreach plan within the community needs assessment to demonstrate how stakeholder
114.8 feedback was solicited and reflected in the plan.

114.9 (b) The applicant or license holder must publicly post a draft community needs assessment
114.10 on the organization's website for 30 days and submit a summary of public comments and
114.11 recommendations from the comment period to the commissioner.

114.12 (c) In the draft community needs assessment, the applicant or license holder must declare
114.13 a planned geographic service delivery area in which the CCBHC will be capable of providing
114.14 all nine required services. An applicant must provide an analysis of how CCBHC status
114.15 will lead to a significant improvement in the availability and quality of the services. An
114.16 existing license holder must include analysis of which needs from prior needs assessments
114.17 have been improved by the operation of the CCBHC. A clinic that has not made and
114.18 demonstrated substantial progress in addressing the identified needs must specify what
114.19 changes will occur to address the lack of progress.

114.20 (d) The commissioner must provide feedback and technical assistance if the community
114.21 needs assessment must be revised.

114.22 Subd. 20. **Staffing plan.** Based on an accepted community needs assessment, the
114.23 applicant or license holder must complete a staffing plan. The staffing plan must include
114.24 analysis of the extent to which identified staffing levels will be capable of meeting the needs
114.25 identified in the community needs assessment.

114.26 Subd. 21. **Data and evaluation.** A provider must submit documentation that establishes
114.27 the ability of the clinic to complete the required data collection as a CCBHC, as determined
114.28 by the commissioner. For an applicant that is an existing provider, the commissioner must
114.29 review and evaluate data submitted related to claims, grants, and other reporting to ensure
114.30 the data meets reporting requirements.

114.31 Subd. 22. **Cost reporting.** A provider must submit a cost report on the forms and in the
114.32 manner required in section 256B.0625, subdivision 5m.

115.1 Sec. 31. **[245I.22] ADULT REHABILITATIVE MENTAL HEALTH SERVICES.**

115.2 Subdivision 1. **Generally.** Beginning January 1, 2028, a provider of adult mental health
115.3 rehabilitative services must be licensed under this section and chapter 245A.

115.4 Subd. 2. **Definitions.** (a) For the purposes of this section, the terms in this subdivision
115.5 have the meanings given.

115.6 (b) "Adult mental health rehabilitative services" or "ARMHS" has the meaning given
115.7 in section 245I.02, subdivision 33.

115.8 (c) "Basic living skills" means rehabilitative interventions that instruct, assist, and support
115.9 the client with:

115.10 (1) interpersonal communication skills;

115.11 (2) community resource utilization and integration skills;

115.12 (3) crisis planning;

115.13 (4) relapse prevention skills;

115.14 (5) health care directives;

115.15 (6) budgeting and shopping skills;

115.16 (7) healthy lifestyle skills and practices;

115.17 (8) cooking and nutrition skills;

115.18 (9) transportation skills;

115.19 (10) mental illness symptom management skills;

115.20 (11) household management skills;

115.21 (12) employment-related skills; and

115.22 (13) parenting skills.

115.23 (d) "Community intervention" means a client's community assisting in the client's
115.24 rehabilitation, including consultation with relatives, guardians, friends, employers, treatment
115.25 providers, and other significant individuals. Community intervention is appropriate when
115.26 directed exclusively to the treatment of the client.

115.27 (e) "Medication education services" means services provided individually or in groups
115.28 that focus on educating the client about mental illness and symptoms, the role and effects
115.29 of medications in treating symptoms of mental illness, and the side effects of medications.
115.30 Medication education services must be coordinated with, but must not duplicate, medication

116.1 management services. Medication education services must be provided by physicians,
116.2 advanced practice registered nurses, pharmacists, physician assistants, or registered nurses.

116.3 (f) "Transition to community living services" means services that maintain continuity
116.4 of contact between the ARMHS provider and the client and facilitate discharge from a
116.5 hospital, residential treatment program, board and lodging facility, or nursing home.
116.6 Transition to community living services must not be used to provide other areas of adult
116.7 rehabilitative mental health services.

116.8 Subd. 3. **Service components.** An ARMHS provider must be capable of providing:

116.9 (1) basic living skills;

116.10 (2) medication education services;

116.11 (3) community intervention; and

116.12 (4) transition to community living services.

116.13 Subd. 4. **Provider requirements.** An ARMHS license holder must be enrolled with
116.14 medical assistance and comply with standards in section 256B.0623.

116.15 Subd. 5. **Qualifications.** ARMHS must be provided by:

116.16 (1) a mental health professional qualified under section 245I.04, subdivision 2;

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

116.18 (3) a clinical trainee qualified under section 245I.04, subdivision 6;

116.19 (4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

116.20 (5) a mental health certified peer specialist qualified under section 245I.04, subdivision
116.21 12; or

116.22 (6) a mental health rehabilitation worker qualified under section 245I.04, subdivision
116.23 14.

116.24 Subd. 6. **Service planning.** (a) An ARMHS provider must complete a written functional
116.25 assessment according to section 245I.10, subdivision 9, for each client.

116.26 (b) When an ARMHS provider completes a written functional assessment, the provider
116.27 must also complete a level of care assessment, as defined in section 245I.02, subdivision
116.28 19, for the client.

116.29 Subd. 7. **Group modality.** ARMHS may be provided in group settings if appropriate
116.30 to each participating client's needs and treatment plan. A group is defined as two to ten

117.1 clients, at least one of whom is concurrently receiving ARMHS. The service and group
117.2 must be specified in the client's individual treatment plan.

117.3 Sec. 32. **[245I.24] MOBILE CRISIS RESPONSE SERVICES.**

117.4 Subdivision 1. **Generally.** (a) Mobile crisis response services provide short-term,
117.5 face-to-face mental health care in community settings for adults and children experiencing
117.6 crisis to help individuals maintain safety and return to a baseline level of functioning.

117.7 (b) Beginning January 1, 2028, a provider of mobile crisis response services must be
117.8 licensed under this section and chapter 245A.

117.9 Subd. 2. **Definitions.** (a) For the purposes of this section, the terms in this subdivision
117.10 have the meanings given.

117.11 (b) "Crisis assessment" means an immediate face-to-face assessment by a physician, a
117.12 mental health professional, or a qualified member of a crisis team, as described in subdivision
117.13 5.

117.14 (c) "Crisis intervention" means face-to-face, short-term intensive mental health services
117.15 initiated during a mental health crisis to help an individual cope with immediate stressors,
117.16 identify and utilize available resources and strengths, engage in voluntary treatment, and
117.17 begin to return to the individual's baseline level of functioning.

117.18 (d) "Crisis screening" means a screening of a client's potential mental health crisis
117.19 situation under subdivision 6.

117.20 (e) "Crisis stabilization services" means individualized mental health services that are
117.21 designed to restore an individual to the individual's baseline level of functioning. Crisis
117.22 stabilization services may be provided in the individual's home, the home of a family member
117.23 or friend of the individual, another community setting, a short-term supervised licensed
117.24 residential program, or an emergency department. Crisis stabilization services include family
117.25 psychoeducation.

117.26 (f) "Crisis team" means the staff of a provider entity who are supervised and prepared
117.27 to provide mobile crisis services to a client in a potential mental health crisis situation.

117.28 (g) "Mental health crisis" is a behavioral, emotional, or psychiatric situation that, without
117.29 the provision of crisis response services, would likely result in significantly reducing the
117.30 individual's levels of functioning in primary activities of daily living, the individual needing
117.31 emergency services under section 62Q.55, or the individual being placed in a more restrictive
117.32 setting, including but not limited to inpatient hospitalization.

118.1 (h) "Mobile crisis services" means screening, assessment, intervention, and
118.2 community-based crisis stabilization services that are provided to an individual client.
118.3 Mobile crisis services does not include residential crisis stabilization.

118.4 Subd. 3. **Eligibility.** (a) An individual is eligible for crisis assessment services when the
118.5 person has screened positive for a potential mental health crisis during a crisis screening.

118.6 (b) An individual is eligible for crisis intervention services and crisis stabilization services
118.7 when the individual has been assessed during a crisis assessment to be experiencing a mental
118.8 health crisis.

118.9 Subd. 4. **Policies, procedures, and practices specified.** (a) In addition to the policies
118.10 and procedures required by section 245I.03, the license holder must establish, enforce, and
118.11 maintain policies and procedures to:

118.12 (1) ensure that crisis screenings, crisis assessments, and crisis intervention services are
118.13 available 24 hours per day, seven days per week;

118.14 (2) respond to a call for services in a designated service area or according to a written
118.15 agreement with the local mental health authority for an adjacent area;

118.16 (3) have at least one mental health professional on staff at all times and at least one
118.17 additional staff member capable of leading a crisis response in the community; and

118.18 (4) respond to clients in the community according to the requirements and priorities in
118.19 subdivision 6.

118.20 (b) The license holder must provide the commissioner with information about the number
118.21 of requests for service, the number of clients that the provider serves face-to-face, and client
118.22 outcomes at least every six months, in a form and manner prescribed by the commissioner.

118.23 (c) The license holder must:

118.24 (1) provide support for an individual's family and natural supports by enabling the
118.25 individual's family and natural supports to observe and participate in the individual's
118.26 treatment, assessments, and planning services;

118.27 (2) implement culturally specific treatment identified in the crisis treatment plan that is
118.28 meaningful and appropriate, as determined by the individual's culture, beliefs, values, and
118.29 language;

118.30 (3) respond to an individual's changing intervention and care needs, as identified by the
118.31 individual or a family member; and

119.1 (4) have the communication tools and procedures to communicate and consult promptly
119.2 about crisis assessment and interventions as services are provided.

119.3 (d) The license holder must coordinate services with:

119.4 (1) county emergency services under section 245.469, community hospitals, ambulance
119.5 services, transportation services, social services, law enforcement, engagement services,
119.6 and mental health crisis services through regularly scheduled interagency meetings;

119.7 (2) other behavioral health service providers, county mental health authorities, or federally
119.8 recognized American Indian authorities, and others as necessary, with the consent of the
119.9 individual or parent or guardian;

119.10 (3) detoxification, withdrawal management services, and medical stabilization services
119.11 as needed; and

119.12 (4) the individual's case manager if the individual is receiving case management services.

119.13 Subd. 5. **Crisis assessment and intervention staff qualifications.** (a) Crisis assessment
119.14 and intervention services must be provided by:

119.15 (1) a mental health professional qualified under section 245I.04, subdivision 2;

119.16 (2) a clinical trainee qualified under section 245I.04, subdivision 6;

119.17 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

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

119.20 (5) a mental health certified peer specialist qualified under section 245I.04, subdivision
119.21 10.

119.22 (b) When crisis assessment and intervention services are provided to an individual in
119.23 the community, a mental health professional, clinical trainee, or mental health practitioner
119.24 must lead the response.

119.25 (c) For providers under this section, the 30 hours of ongoing training required by section
119.26 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children
119.27 and adults and include training about evidence-based practices identified by the commissioner
119.28 of health to reduce the individual's risk of suicide and self-injurious behavior.

119.29 (d) At least six hours of the ongoing training under paragraph (c) must be specific to
119.30 working with families and providing crisis stabilization services to children and include the
119.31 following topics:

120.1 (1) developmental tasks of childhood and adolescence;

120.2 (2) family relationships;

120.3 (3) child and youth engagement and motivation, including motivational interviewing;

120.4 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
120.5 queer youth;

120.6 (5) positive behavior support;

120.7 (6) crisis intervention for youth with developmental disabilities;

120.8 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
120.9 therapy; and

120.10 (8) youth substance use.

120.11 (e) Individual providers must be experienced in crisis assessment, crisis intervention
120.12 techniques, treatment engagement strategies, working with families, and clinical decision
120.13 making under emergency conditions and have knowledge of local services and resources.

120.14 Subd. 6. **Crisis screening.** (a) A license holder may use the resources of emergency
120.15 services under section 245.469 for crisis screening. The crisis screening must gather
120.16 information, determine whether a mental health crisis situation exists, identify parties
120.17 involved, and determine an appropriate response.

120.18 (b) When conducting a crisis screening, a provider must:

120.19 (1) employ evidence-based practices to reduce the individual's risk of suicide and
120.20 self-injurious behavior;

120.21 (2) work with the individual to establish a plan and time frame for responding to the
120.22 individual's mental health crisis, including responding to the individual's immediate need
120.23 for support by telephone or text message until the provider can respond to the individual
120.24 face-to-face;

120.25 (3) document significant factors in determining whether the individual is experiencing
120.26 a mental health crisis, including prior requests for crisis services, an individual's recent
120.27 presentation at an emergency department, known calls to 911 or law enforcement, or
120.28 information from third parties with knowledge of an individual's history or current needs;

120.29 (4) accept calls from interested third parties and consider the additional needs or potential
120.30 mental health crises that the third parties may be experiencing;

121.1 (5) provide psychoeducation, including reducing access to means of suicide, to relevant
121.2 third parties including family members or other persons living with the individual; and

121.3 (6) consider other available services to determine which service intervention would best
121.4 address the individual's needs and circumstances.

121.5 (c) For the purposes of this section, the following situations indicate a positive screen
121.6 for a potential mental health crisis:

121.7 (1) the individual presents at an emergency department or urgent care setting and the
121.8 health care team at that location requested crisis services; or

121.9 (2) a peace officer requested crisis services for an individual who is potentially subject
121.10 to transportation under section 253B.051.

121.11 (d) The provider must prioritize providing a face-to-face crisis assessment of the
121.12 individual, unless a provider documents specific evidence to show why the face-to-face
121.13 assessment was not possible, including insufficient staffing resources, concerns for staff or
121.14 individual safety, or other clinical factors.

121.15 (e) A provider is not required to have direct contact with the individual to determine
121.16 that the individual is experiencing a potential mental health crisis. A mobile crisis provider
121.17 may gather relevant information about the individual from a third party to establish the
121.18 individual's need for services and potential safety factors.

121.19 Subd. 7. **Crisis assessment.** (a) If an individual screens positive for a potential mental
121.20 health crisis, a crisis assessment must be completed. A crisis assessment must evaluate any
121.21 immediate needs for which services are needed and, as time permits, the individual's:

121.22 (1) current life situation;

121.23 (2) health information, including current medications;

121.24 (3) sources of stress;

121.25 (4) mental health problems and symptoms;

121.26 (5) strengths;

121.27 (6) cultural considerations;

121.28 (7) support network;

121.29 (8) vulnerabilities;

121.30 (9) current functioning; and

122.1 (10) preferences, as communicated directly by the individual or as communicated in a
122.2 health care directive as described in chapters 145C and 253B, the crisis treatment plan
122.3 described in subdivision 11, a crisis prevention plan, or a wellness recovery action plan.

122.4 (b) A provider must conduct a crisis assessment at the individual's location when
122.5 appropriate and, when not appropriate, document the reasons.

122.6 (c) Whenever possible, the assessor must attempt to include input from the individual,
122.7 the individual's family, and other natural supports to assess whether a crisis exists.

122.8 (d) A crisis assessment must include a determination of:

122.9 (1) whether the individual is willing to voluntarily engage in treatment;

122.10 (2) whether the individual has an advance directive; and

122.11 (3) gathering the individual's information and history from involved family or other
122.12 natural supports.

122.13 (e) If a team determines that the individual does not need an acute level of care, the team
122.14 must provide services or service coordination if the individual has a co-occurring substance
122.15 use disorder and is otherwise eligible for services.

122.16 (f) If, after completing a crisis assessment, a provider refers the individual to an intensive
122.17 setting, including an emergency department, inpatient hospitalization, or residential crisis
122.18 stabilization, one of the crisis team members who completed or conferred about the
122.19 individual's crisis assessment must immediately contact the referral entity and consult with
122.20 the staff responsible for triage or intake at the referral entity. During the consultation, the
122.21 crisis team member must convey key findings or concerns that led to the individual's referral.
122.22 Following the consultation, the provider must also send written documentation to the referral
122.23 entity. The provider must document if the individual or the individual's legal guardian signed
122.24 releases for health records or if an exception under section 144.293, subdivision 5, exists.

122.25 Subd. 8. **Crisis intervention services.** (a) If the crisis assessment determines an individual
122.26 needs mobile crisis intervention services, the license holder must provide crisis intervention
122.27 services promptly. As able during the intervention, at least two members of the mobile crisis
122.28 intervention team must confer directly or by telephone about the crisis assessment, crisis
122.29 treatment plan, and actions taken and needed. At least one of the team members must be
122.30 providing face-to-face crisis intervention services. If providing crisis intervention services,
122.31 a clinical trainee or mental health practitioner must seek treatment supervision as required
122.32 in subdivision 10.

123.1 (b) If a provider delivers crisis intervention services while the individual is absent, the
123.2 provider must document the reason for delivering services while the individual is absent.

123.3 (c) The mobile crisis intervention team must develop a crisis treatment plan according
123.4 to subdivision 11.

123.5 (d) The mobile crisis intervention team must document which crisis treatment plan goals
123.6 and objectives have been met and when no further crisis intervention services are required.

123.7 (e) If the individual's mental health crisis is stabilized, but the individual needs a referral
123.8 to other services, the team must provide referrals to these services. If the individual is unable
123.9 to follow up on the referral, the team must link the individual to the service and follow up
123.10 to ensure the individual is receiving the service.

123.11 Subd. 9. **Crisis stabilization services.** (a) Crisis stabilization services must be provided
123.12 by qualified staff of a crisis stabilization services provider entity, which must:

123.13 (1) develop a crisis treatment plan that meets the criteria in subdivision 11;

123.14 (2) complete a vulnerable adult determination in accordance with section 245A.65,
123.15 subdivision 1a;

123.16 (3) deliver crisis stabilization services according to the crisis treatment plan and include
123.17 face-to-face contact with the individual receiving services by qualified staff for further
123.18 assessment, help with referrals, updating of the crisis treatment plan, skills training, and
123.19 collaboration with other service providers in the community;

123.20 (4) if the provider delivers crisis stabilization services while the individual is absent,
123.21 document the reason for delivering services while the individual is absent; and

123.22 (5) if the individual's mental health crisis is stabilized and the individual does not have
123.23 a health care directive or psychiatric declaration, as defined in chapter 145C or section
123.24 253B.03, subdivision 6d, offer to work with the individual to develop a directive or
123.25 declaration.

123.26 (b) A staff member providing crisis stabilization services must be:

123.27 (1) a mental health professional qualified under section 245I.04, subdivision 2;

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

123.29 (3) a clinical trainee qualified under section 245I.04, subdivision 6;

123.30 (4) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

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

124.3 (6) a mental health certified peer specialist qualified under section 245I.04, subdivision
124.4 10; or

124.5 (7) a mental health rehabilitation worker qualified under section 245I.04, subdivision
124.6 14.

124.7 (c) For providers under this section, the 30 hours of ongoing training required in section
124.8 245I.05, subdivision 4, paragraph (b), must be specific to providing crisis services to children
124.9 and adults and include training about evidence-based practices identified by the commissioner
124.10 of health to reduce an individual's risk of suicide and self-injurious behavior.

124.11 (d) For providers who deliver care to children 21 years of age or younger, at least six
124.12 hours of the ongoing training under this subdivision must be specific to working with families
124.13 and providing crisis stabilization services to children, including the following topics:

124.14 (1) developmental tasks of childhood and adolescence;

124.15 (2) family relationships;

124.16 (3) child and youth engagement and motivation, including motivational interviewing;

124.17 (4) culturally responsive care, including care for lesbian, gay, bisexual, transgender, and
124.18 queer youth;

124.19 (5) positive behavior support;

124.20 (6) crisis intervention for youth with developmental disabilities;

124.21 (7) child traumatic stress, trauma-informed care, and trauma-focused cognitive behavioral
124.22 therapy; and

124.23 (8) youth substance use.

124.24 This paragraph does not apply to adult residential crisis stabilization services providers
124.25 licensed under section 245I.23 or providing services pursuant to section 256B.0624,
124.26 subdivision 7a.

124.27 Subd. 10. **Supervision.** Clinical trainees and mental health practitioners may provide
124.28 crisis assessment and crisis intervention services if the following treatment supervision
124.29 requirements are met:

124.30 (1) the license holder must accept full responsibility for the services provided;

125.1 (2) a mental health professional working for the license holder must be immediately
125.2 available by telephone or in person for treatment supervision;

125.3 (3) a mental health professional must be consulted, in person or by telephone, during
125.4 the first three hours when a clinical trainee or mental health practitioner provides crisis
125.5 assessment or crisis intervention services; and

125.6 (4) a mental health professional must:

125.7 (i) review and approve, as defined in section 245I.02, subdivision 2, the tentative crisis
125.8 assessment and crisis treatment plan within 24 hours of first providing services to the
125.9 individual, notwithstanding section 245I.08, subdivision 3; and

125.10 (ii) document the consultation required in clause (3).

125.11 Subd. 11. **Crisis treatment plan.** (a) Within 24 hours of an individual's admission, the
125.12 license holder must complete the individual's crisis treatment plan. The license holder must:

125.13 (1) base the individual's crisis treatment plan on the individual's crisis assessment;

125.14 (2) consider crisis assistance strategies that have been effective for the individual in the
125.15 past;

125.16 (3) for a child, use a child-centered, family-driven, and culturally appropriate planning
125.17 process that allows the child's parents and guardians to observe or participate in the child's
125.18 individual and family treatment services, assessment, and treatment planning;

125.19 (4) for an adult, use a person-centered, culturally appropriate planning process that allows
125.20 the individual's family and other natural supports to observe or participate in treatment
125.21 services, assessment, and treatment planning;

125.22 (5) identify the participants involved in the individual's treatment planning. The individual
125.23 must be a participant if possible;

125.24 (6) identify the individual's initial treatment goals, measurable treatment objectives, and
125.25 specific interventions that the license holder will use to help the person engage in treatment;

125.26 (7) include documentation of referral to and scheduling of services, including specific
125.27 providers where applicable;

125.28 (8) ensure that the individual or the individual's legal guardian approves under section
125.29 245I.02, subdivision 2, of the individual's crisis treatment plan unless a court orders the
125.30 individual's treatment plan under chapter 253B. If the individual or the individual's legal
125.31 guardian disagrees with the crisis treatment plan, the license holder must document in the
125.32 client file the reasons why the individual disagrees with the crisis treatment plan; and

126.1 (9) ensure that a treatment supervisor approves, as defined in section 245I.02, subdivision
126.2 2, of the individual's treatment plan within 24 hours of the individual's admission if a mental
126.3 health practitioner or clinical trainee completes the crisis treatment plan, notwithstanding
126.4 section 245I.08, subdivision 3.

126.5 (b) The provider entity must provide the individual and the individual's legal guardian
126.6 with a copy of the crisis treatment plan.

126.7 Subd. 12. **Application requirements.** In a licensing application submitted under this
126.8 section and section 245A.04, the applicant must demonstrate that the applicant is:

126.9 (1) enrolled as a medical assistance provider; and

126.10 (2) in compliance with the provider type requirements under section 256B.0624,
126.11 subdivision 4, as determined by the commissioner.

126.12 Sec. 33. **[245I.30] CHILDREN'S THERAPEUTIC SERVICES AND SUPPORTS.**

126.13 Subdivision 1. **Generally.** (a) "Children's therapeutic services and supports" means a
126.14 flexible package of community-based mental health services for children who require varying
126.15 therapeutic and rehabilitative levels of intervention to treat a diagnosed mental illness.
126.16 Interventions are delivered using various treatment modalities and combinations of services
126.17 designed to reach treatment outcomes identified in the individual treatment plan. Children's
126.18 therapeutic services and supports include development and rehabilitative services that
126.19 support a child's developmental treatment needs.

126.20 (b) Beginning January 1, 2028, a provider of children's therapeutic services and supports
126.21 must be licensed under this section and chapter 245A.

126.22 Subd. 2. **Service components.** (a) A children's therapeutic services and supports license
126.23 holder must be capable of providing:

126.24 (1) individual and family psychotherapy, psychotherapy for crises, and group
126.25 psychotherapy;

126.26 (2) individual, family, or group skills training; and

126.27 (3) crisis planning.

126.28 (b) Crisis planning that meets the standards in section 245.4871, subdivision 9a, must
126.29 be offered to each client's family.

127.1 Subd. 3. **Provider requirements.** A children's therapeutic services and supports license
127.2 holder must be enrolled with medical assistance and comply with the requirements in section
127.3 256B.0943.

127.4 Subd. 4. **Qualifications of provider staff.** Children's therapeutic services and supports
127.5 must be provided by:

127.6 (1) a mental health professional qualified under section 245I.04, subdivision 2;

127.7 (2) a clinical trainee qualified under section 245I.04, subdivision 6;

127.8 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4;

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

127.11 (5) a mental health behavioral aide qualified under section 245I.04, subdivision 16.

127.12 Subd. 5. **Group modality.** Group skills training may be provided to multiple clients
127.13 who, because of the nature of the clients' emotional, behavioral, or social dysfunction, can
127.14 derive mutual benefit from interaction in a group setting. A group must consist of two to
127.15 ten clients, at least one of whom is a client and is concurrently receiving a service under
127.16 this section. The service and group must be specified in the client's individual treatment
127.17 plan.

127.18 Sec. 34. **[245I.31] CHILDREN'S DAY TREATMENT.**

127.19 Subdivision 1. **Generally.** (a) For the purposes of this section, "children's day treatment
127.20 program" means a site-based structured mental health program consisting of psychotherapy
127.21 and individual or group skills training provided by a team under the treatment supervision
127.22 of a mental health professional.

127.23 (b) A children's day treatment program must be licensed for a specific location of
127.24 operation and must not be part of inpatient or residential treatment services.

127.25 (c) A children's day treatment program must stabilize a client's mental health status while
127.26 developing and improving the client's independent living and socialization skills. The goal
127.27 of the day treatment program must be to reduce or relieve the effects of mental illness and
127.28 provide training to enable the client to live in the community.

127.29 (d) Beginning January 1, 2028, a provider of children's day services must be licensed
127.30 under this section and chapter 245A.

128.1 Subd. 2. **Service components.** A children's day treatment program must be capable of
128.2 providing the services in section 245I.30, subdivision 2.

128.3 Subd. 3. **Provider requirements.** A children's day treatment license holder must:

128.4 (1) be enrolled as a provider with medical assistance;

128.5 (2) maintain a policy regarding the use of restrictive procedures and meet the requirements
128.6 of section 245.8261;

128.7 (3) maintain a policy on medications in accordance with section 245I.11, subdivision
128.8 6; and

128.9 (4) meet group modality requirements in section 245I.30, subdivision 5.

128.10 Subd. 4. **Qualifications of provider staff.** Children's day treatment services must be
128.11 provided by:

128.12 (1) a mental health professional qualified under section 245I.04, subdivision 2;

128.13 (2) a clinical trainee qualified under section 245I.04, subdivision 6; or

128.14 (3) a behavioral health practitioner qualified under section 245I.04, subdivision 4.

128.15 Sec. 35. Minnesota Statutes 2024, section 256B.0623, subdivision 1, is amended to read:

128.16 Subdivision 1. **Scope.** ~~Subject to federal approval,~~ Medical assistance covers medically
128.17 necessary adult rehabilitative mental health services when the services are provided by an
128.18 entity ~~meeting the standards in this section~~ licensed under section 245I.24. The provider
128.19 entity must make reasonable and good faith efforts to report individual client outcomes to
128.20 the commissioner, using instruments and protocols approved by the commissioner.

128.21 **EFFECTIVE DATE.** This section is effective January 1, 2028.

128.22 Sec. 36. Minnesota Statutes 2024, section 256B.0623, subdivision 3, is amended to read:

128.23 Subd. 3. **Eligibility.** An eligible recipient is an individual who:

128.24 (1) is age 18 or older;

128.25 (2) is diagnosed with a medical condition, such as mental illness or traumatic brain
128.26 injury, for which adult rehabilitative mental health services are needed;

128.27 (3) has substantial disability and functional impairment in three or more of the areas
128.28 listed in section 245I.10, subdivision 9, paragraph (a), clause (4), so that self-sufficiency is
128.29 markedly reduced; and

(4) has had a recent standard diagnostic assessment pursuant to section 245I.10, subdivision 6, by a qualified professional that documents adult rehabilitative mental health services are medically necessary to address identified disability and functional impairments and individual recipient goals.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 37. Minnesota Statutes 2024, section 256B.0623, subdivision 12, is amended to read:

Subd. 12. **Additional requirements.** ~~(a) Providers of adult rehabilitative mental health services must comply with the requirements relating to referrals for case management in section 245.467, subdivision 4.~~

~~(b) Adult rehabilitative mental health services are provided for most recipients in the recipient's home and community. Services may also be provided at the home of a relative or significant other, job site, psychosocial clubhouse, drop-in center, social setting, classroom, or other places in the community.~~ (a) Except for "transition to community services," the place of service does not include a regional treatment center, nursing home, residential treatment facility licensed under Minnesota Rules, parts 9520.0500 to 9520.0670 (Rule 36), or section 245I.23, or an acute care hospital.

~~(c) Adult rehabilitative mental health services may be provided in group settings if appropriate to each participating recipient's needs and individual treatment plan. A group is defined as two to ten clients, at least one of whom is a recipient, who is concurrently receiving a service which is identified in this section. The service and group must be specified in the recipient's individual treatment plan.~~ (b) No more than two qualified staff may bill Medicaid for services provided to the same group of recipients. If two adult rehabilitative mental health workers bill for recipients in the same group session, they must each bill for different recipients.

~~(d)~~ (c) Adult rehabilitative mental health services are appropriate if provided to enable a recipient to retain stability and functioning, when the recipient is at risk of significant functional decompensation or requiring more restrictive service settings without these services.

~~(e) Adult rehabilitative mental health services instruct, assist, and support the recipient in areas including: interpersonal communication skills, community resource utilization and integration skills, crisis planning, relapse prevention skills, health care directives, budgeting and shopping skills, healthy lifestyle skills and practices, cooking and nutrition skills, transportation skills, medication education and monitoring, mental illness symptom~~

130.1 ~~management skills, household management skills, employment-related skills, parenting~~
130.2 ~~skills, and transition to community living services.~~

130.3 ~~(f) Community intervention, including consultation with relatives, guardians, friends,~~
130.4 ~~employers, treatment providers, and other significant individuals, is appropriate when~~
130.5 ~~directed exclusively to the treatment of the client.~~

130.6 **EFFECTIVE DATE.** This section is effective January 1, 2028.

130.7 Sec. 38. Minnesota Statutes 2024, section 256B.0624, subdivision 1, is amended to read:

130.8 Subdivision 1. **Scope.** (a) ~~Subject to federal approval,~~ Medical assistance covers medically
130.9 necessary crisis response services when the services are provided according to the standards
130.10 in ~~this~~ section 245I.24.

130.11 (b) ~~Subject to federal approval,~~ Medical assistance covers medically necessary residential
130.12 crisis stabilization for adults when the services are provided by an entity licensed under and
130.13 meeting the standards in section 245I.23 or an entity with an adult foster care license meeting
130.14 the standards in ~~this section~~ subdivision 7a.

130.15 (c) The provider entity must make reasonable and good faith efforts to report individual
130.16 client outcomes to the commissioner using instruments and protocols approved by the
130.17 commissioner.

130.18 **EFFECTIVE DATE.** This section is effective January 1, 2028.

130.19 Sec. 39. Minnesota Statutes 2024, section 256B.0624, subdivision 4, is amended to read:

130.20 Subd. 4. **Provider entity standards.** (a) A mobile crisis provider must be:

130.21 (1) a county board operated entity;

130.22 (2) an Indian health services facility or facility owned and operated by a tribe or Tribal
130.23 organization operating under United States Code, title 325, section 450f; or

130.24 (3) a provider entity that is under contract with the county board in the county where
130.25 the potential crisis or emergency is occurring. To provide services under this section, the
130.26 provider entity must directly provide the services; or if services are subcontracted, the
130.27 provider entity must maintain responsibility for services and billing.

130.28 ~~(b) A mobile crisis provider must meet the following standards:~~

130.29 ~~(1) ensure that crisis screenings, crisis assessments, and crisis intervention services are~~
130.30 ~~available to a recipient 24 hours a day, seven days a week;~~

131.1 ~~(2) be able to respond to a call for services in a designated service area or according to~~
131.2 ~~a written agreement with the local mental health authority for an adjacent area;~~

131.3 ~~(3) have at least one mental health professional on staff at all times and at least one~~
131.4 ~~additional staff member capable of leading a crisis response in the community; and~~

131.5 ~~(4) provide the commissioner with information about the number of requests for service,~~
131.6 ~~the number of people that the provider serves face-to-face, outcomes, and the protocols that~~
131.7 ~~the provider uses when deciding when to respond in the community.~~

131.8 ~~(c) A provider entity that provides crisis stabilization services in a residential setting~~
131.9 ~~under subdivision 7 is not required to meet the requirements of paragraphs (a) and (b), but~~
131.10 ~~must meet all other requirements of this subdivision.~~

131.11 ~~(d) A crisis services provider must have the capacity to meet and carry out the standards~~
131.12 ~~in section 245I.011, subdivision 5, and the following standards:~~

131.13 ~~(1) ensures that staff persons provide support for a recipient's family and natural supports,~~
131.14 ~~by enabling the recipient's family and natural supports to observe and participate in the~~
131.15 ~~recipient's treatment, assessments, and planning services;~~

131.16 ~~(2) has adequate administrative ability to ensure availability of services;~~

131.17 ~~(3) is able to ensure that staff providing these services are skilled in the delivery of~~
131.18 ~~mental health crisis response services to recipients;~~

131.19 ~~(4) is able to ensure that staff are implementing culturally specific treatment identified~~
131.20 ~~in the crisis treatment plan that is meaningful and appropriate as determined by the recipient's~~
131.21 ~~culture, beliefs, values, and language;~~

131.22 ~~(5) is able to ensure enough flexibility to respond to the changing intervention and care~~
131.23 ~~needs of a recipient as identified by the recipient or family member during the service~~
131.24 ~~partnership between the recipient and providers;~~

131.25 ~~(6) is able to ensure that staff have the communication tools and procedures to~~
131.26 ~~communicate and consult promptly about crisis assessment and interventions as services~~
131.27 ~~occur;~~

131.28 ~~(7) is able to coordinate these services with county emergency services, community~~
131.29 ~~hospitals, ambulance, transportation services, social services, law enforcement, engagement~~
131.30 ~~services, and mental health crisis services through regularly scheduled interagency meetings;~~

131.31 ~~(8) is able to ensure that services are coordinated with other behavioral health service~~
131.32 ~~providers, county mental health authorities, or federally recognized American Indian~~

132.1 ~~authorities and others as necessary, with the consent of the recipient or parent or guardian.~~
132.2 ~~Services must also be coordinated with the recipient's case manager if the recipient is~~
132.3 ~~receiving case management services;~~

132.4 ~~(9) is able to ensure that crisis intervention services are provided in a manner consistent~~
132.5 ~~with sections 245.461 to 245.486 and 245.487 to 245.4879;~~

132.6 ~~(10) is able to coordinate detoxification services for the recipient according to Minnesota~~
132.7 ~~Rules, parts 9530.6605 to 9530.6655, or withdrawal management according to chapter 245F;~~

132.8 ~~(11) is able to establish and maintain a quality assurance and evaluation plan to evaluate~~
132.9 ~~the outcomes of services and recipient satisfaction; and~~

132.10 ~~(12) is an enrolled medical assistance provider.~~

132.11 (b) A mobile crisis provider must ensure services are provided consistent with section
132.12 245.469, subdivisions 1 and 2.

132.13 **EFFECTIVE DATE.** This section is effective January 1, 2028.

132.14 Sec. 40. Minnesota Statutes 2024, section 256B.0624, is amended by adding a subdivision
132.15 to read:

132.16 Subd. 7a. **Residential crisis stabilization services in adult foster care settings.** (a) If
132.17 crisis stabilization services are provided in a supervised, licensed residential setting that
132.18 serves no more than four adult residents, and one or more individuals are present at the
132.19 setting to receive residential crisis stabilization, the residential setting staff must include,
132.20 for at least eight hours per day, at least one mental health professional, clinical trainee,
132.21 certified rehabilitation specialist, or mental health practitioner.

132.22 (b) The commissioner must establish a statewide per diem rate for crisis stabilization
132.23 services provided under this paragraph to medical assistance enrollees. The rate for a provider
132.24 must not exceed the rate charged by that provider for the same service to other payers.
132.25 Payment must not be made to more than one entity for each individual for services provided
132.26 under this paragraph on a given day. The commissioner must set rates prospectively for the
132.27 annual rate period. The commissioner must require providers to submit annual cost reports
132.28 on a uniform cost reporting form and use submitted cost reports to inform the rate-setting
132.29 process. The commissioner must recalculate the statewide per diem every year.

132.30 (c) A provider under this subdivision must follow the requirements under section 245I.24,
132.31 subdivisions 4, paragraphs (c) and (d), and 9.

132.32 **EFFECTIVE DATE.** This section is effective January 1, 2028.

Sec. 41. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 5m, is amended to read:

Subd. 5m. **Certified community behavioral health clinic services.** (a) Medical assistance covers services provided by a not-for-profit certified community behavioral health clinic (CCBHC) that meets the requirements of section ~~245.735, subdivision 3~~ 245I.17.

(b) The commissioner shall reimburse CCBHCs on a per-day basis for each day that an eligible service is delivered using the CCBHC daily bundled rate system for medical assistance payments as described in paragraph (c). The commissioner shall include a quality incentive payment in the CCBHC daily bundled rate system as described in paragraph (e). There is no county share for medical assistance services when reimbursed through the CCBHC daily bundled rate system.

(c) The commissioner shall ensure that the CCBHC daily bundled rate system for CCBHC payments under medical assistance meets the following requirements:

(1) the CCBHC daily bundled rate shall be a provider-specific rate calculated for each CCBHC, based on the daily cost of providing CCBHC services and the total annual allowable CCBHC costs divided by the total annual number of CCBHC visits. For calculating the payment rate, total annual visits include visits covered by medical assistance and visits not covered by medical assistance. Allowable costs include but are not limited to the salaries and benefits of medical assistance providers; the cost of CCBHC services provided under section ~~245.735, subdivision 3, paragraph (a), clauses (6) and (7)~~ 245I.17, subdivision 4; and other costs such as insurance or supplies needed to provide CCBHC services;

(2) payment shall be limited to one payment per day per medical assistance enrollee when an eligible CCBHC service is provided. A CCBHC visit is eligible for reimbursement if at least one of the CCBHC services listed under section ~~245.735, subdivision 3, paragraph (a), clause (6)~~ 245I.17, subdivision 4, is furnished to a medical assistance enrollee by a health care practitioner or licensed agency employed by or under contract with a CCBHC;

(3) initial CCBHC daily bundled rates for newly ~~certified~~ licensed CCBHCs under section ~~245.735, subdivision 3~~ 245I.17, shall be established by the commissioner using a provider-specific rate based on the newly ~~certified~~ licensed CCBHC's audited historical cost report data adjusted for the expected cost of delivering CCBHC services. Estimates are subject to review by the commissioner and must include the expected cost of providing the full scope of CCBHC services and the expected number of visits for the rate period;

(4) the commissioner shall rebase CCBHC rates once every two years following the last rebasing and no less than 12 months following an initial rate or a rate change due to a change

134.1 in the scope of services. For CCBHCs certified after September 30, 2020, and before January
134.2 1, 2021, the commissioner shall rebase rates according to this clause for services provided
134.3 on or after January 1, 2024;

134.4 (5) the commissioner shall provide for a 60-day appeals process after notice of the results
134.5 of the rebasing;

134.6 (6) an entity that receives a CCBHC daily bundled rate that overlaps with another federal
134.7 Medicaid rate is not eligible for the CCBHC rate methodology;

134.8 (7) payments for CCBHC services to individuals enrolled in managed care shall be
134.9 coordinated with the state's phase-out of CCBHC wrap payments. The commissioner shall
134.10 complete the phase-out of CCBHC wrap payments within 60 days of the implementation
134.11 of the CCBHC daily bundled rate system in the Medicaid Management Information System
134.12 (MMIS), for CCBHCs reimbursed under this chapter, with a final settlement of payments
134.13 due made payable to CCBHCs no later than 18 months thereafter;

134.14 (8) the CCBHC daily bundled rate for each CCBHC shall be updated by trending each
134.15 provider-specific rate by the Medicare Economic Index for primary care services. This
134.16 update shall occur each year in between rebasing periods determined by the commissioner
134.17 in accordance with clause (4). CCBHCs must provide data on costs and visits to the state
134.18 annually using the CCBHC cost report established by the commissioner; and

134.19 (9) a CCBHC may request a rate adjustment for changes in the CCBHC's scope of
134.20 services when such changes are expected to result in an adjustment to the CCBHC payment
134.21 rate by 2.5 percent or more. The CCBHC must provide the commissioner with information
134.22 regarding the changes in the scope of services, including the estimated cost of providing
134.23 the new or modified services and any projected increase or decrease in the number of visits
134.24 resulting from the change. Estimated costs are subject to review by the commissioner. Rate
134.25 adjustments for changes in scope shall occur no more than once per year in between rebasing
134.26 periods per CCBHC and are effective on the date of the annual CCBHC rate update.

134.27 (d) Managed care plans and county-based purchasing plans shall reimburse CCBHC
134.28 providers at the CCBHC daily bundled rate. The commissioner shall monitor the effect of
134.29 this requirement on the rate of access to the services delivered by CCBHC providers. If, for
134.30 any contract year, federal approval is not received for this paragraph, the commissioner
134.31 must adjust the capitation rates paid to managed care plans and county-based purchasing
134.32 plans for that contract year to reflect the removal of this provision. Contracts between
134.33 managed care plans and county-based purchasing plans and providers to whom this paragraph
134.34 applies must allow recovery of payments from those providers if capitation rates are adjusted

135.1 in accordance with this paragraph. Payment recoveries must not exceed the amount equal
135.2 to any increase in rates that results from this provision. This paragraph expires if federal
135.3 approval is not received for this paragraph at any time.

135.4 (e) The commissioner shall implement a quality incentive payment program for CCBHCs
135.5 that meets the following requirements:

135.6 (1) a CCBHC shall receive a quality incentive payment upon meeting specific numeric
135.7 thresholds for performance metrics established by the commissioner, in addition to payments
135.8 for which the CCBHC is eligible under the CCBHC daily bundled rate system described in
135.9 paragraph (c);

135.10 (2) a CCBHC must be ~~certified~~ licensed and enrolled as a CCBHC for the entire
135.11 measurement year to be eligible for incentive payments;

135.12 (3) each CCBHC shall receive written notice of the criteria that must be met in order to
135.13 receive quality incentive payments at least 90 days prior to the measurement year; and

135.14 (4) a CCBHC must provide the commissioner with data needed to determine incentive
135.15 payment eligibility within six months following the measurement year. The commissioner
135.16 shall notify CCBHC providers of their performance on the required measures and the
135.17 incentive payment amount within 12 months following the measurement year.

135.18 (f) All claims to managed care plans for CCBHC services as provided under this section
135.19 shall be submitted directly to, and paid by, the commissioner on the dates specified no later
135.20 than January 1 of the following calendar year, if:

135.21 (1) one or more managed care plans does not comply with the federal requirement for
135.22 payment of clean claims to CCBHCs, as defined in Code of Federal Regulations, title 42,
135.23 section 447.45(b), and the managed care plan does not resolve the payment issue within 30
135.24 days of noncompliance; and

135.25 (2) the total amount of clean claims not paid in accordance with federal requirements
135.26 by one or more managed care plans is 50 percent of, or greater than, the total CCBHC claims
135.27 eligible for payment by managed care plans.

135.28 If the conditions in this paragraph are met between January 1 and June 30 of a calendar
135.29 year, claims shall be submitted to and paid by the commissioner beginning on January 1 of
135.30 the following year. If the conditions in this paragraph are met between July 1 and December
135.31 31 of a calendar year, claims shall be submitted to and paid by the commissioner beginning
135.32 on July 1 of the following year.

(g) Peer services provided by a CCBHC ~~certified~~ licensed under section ~~245.735~~ 245I.17 are a covered service under medical assistance when a licensed mental health professional or alcohol and drug counselor determines that peer services are medically necessary. Eligibility under this subdivision for peer services provided by a CCBHC supersede eligibility standards under sections 256B.0615, 256B.0616, and 245G.07, subdivision 2a, paragraph (b), clause (2).

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 42. Minnesota Statutes 2024, section 256B.0943, subdivision 2, is amended to read:

Subd. 2. **Covered service components of children's therapeutic services and supports.** (a) Subject to federal approval, medical assistance covers medically necessary children's therapeutic services and supports when the services are provided by an eligible provider entity ~~certified under and meeting the standards in this section~~ licensed under section 245I.30 or children's day treatment services licensed under section 245I.31. The provider entity must make reasonable and good faith efforts to report individual client outcomes to the commissioner, using instruments and protocols approved by the commissioner.

(b) The covered service components of children's therapeutic services and supports are:

~~(1) patient and/or family psychotherapy, family psychotherapy, psychotherapy for crisis, and group psychotherapy;~~

~~(2) individual, family, or group skills training provided by a mental health professional, clinical trainee, or mental health practitioner;~~

~~(3) crisis planning;~~

~~(4) mental health behavioral aide services;~~

(1) the services described in section 245I.30, subdivision 2, provided by providers licensed under section 245I.30 or 245I.31;

(2) administration of standardized measures;

~~(5)~~ (3) direction of a mental health behavioral aide; and

~~(6)~~ (4) mental health service plan development~~; and~~.

~~(7) children's day treatment.~~

(c) In delivering services under this section, a licensed provider entity must ensure that psychotherapy to address a child's underlying mental health disorder is documented as part

of the child's ongoing treatment. A provider must deliver or arrange for medically necessary psychotherapy unless the child's parent or caregiver chooses not to receive the psychotherapy or the provider determines that psychotherapy is no longer medically necessary. When a provider determines that psychotherapy is no longer medically necessary, the provider must update required documentation, including but not limited to the individual treatment plan, the child's medical record, or other authorizations, to include the determination. When a provider determines that a child needs psychotherapy but psychotherapy cannot be delivered due to a shortage of licensed mental health professionals in the child's community, the provider must document the lack of access in the child's medical record.

(d) Medical assistance covers service plan development before completion of a child's individual treatment plan. Service plan development consists of development, review, and revision of the individual treatment plan by face-to-face or electronic communication, including time spent gathering client history from other key figures or providers. The provider must document events, including the time spent with the family and other key participants in the child's life to approve the individual treatment plan. Service plan development is covered only if a treatment plan is completed or for work already completed at the time the client voluntarily chooses to disengage with services for the child. If it is determined upon review that a treatment plan was not completed for the child, the commissioner shall recover the payment for the service plan development.

(e) Medical assistance covers time spent administering and reporting standardized measures approved by the commissioner.

EFFECTIVE DATE. This section is effective January 1, 2028.

Sec. 43. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 3, is amended to read:

Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's therapeutic services and supports under this section shall be determined based on a standard diagnostic assessment by a mental health professional or a clinical trainee that is performed within one year before the initial start of service and updated as required under section 245I.10, subdivision 2. The standard diagnostic assessment must:

(1) determine whether ~~a child under age 18 has a diagnosis of mental illness or, if the person is between the ages of 18 and 21, whether~~ the person has a mental illness; and

(2) document children's therapeutic services and supports as medically necessary to address an identified disability, functional impairment, and the individual client's needs and goals~~; and~~.

~~(3) be used in the development of the individual treatment plan.~~

(b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to five days of day treatment under this section based on a hospital's medical history and presentation examination of the client.

~~(c) Children's therapeutic services and supports include development and rehabilitative services that support a child's developmental treatment needs.~~

Sec. 44. Minnesota Statutes 2025 Supplement, section 256B.0943, subdivision 12, is amended to read:

Subd. 12. **Excluded services.** (a) The following services are not eligible for medical assistance payment as children's therapeutic services and supports:

(1) service components of children's therapeutic services and supports simultaneously provided by more than one provider entity unless prior authorization is obtained;

(2) treatment by multiple providers within the same agency at the same clock time, unless one service is delivered to the child and the other service is delivered to the child's family or treatment team without the child present;

(3) children's therapeutic services and supports provided in violation of medical assistance policy in Minnesota Rules, part 9505.0220;

(4) mental health behavioral aide services provided by a personal care assistant who is not qualified as a mental health behavioral aide and employed by a certified children's therapeutic services and supports provider entity;

(5) service components of CTSS that are the responsibility of a residential or program license holder, including foster care providers under the terms of a service agreement or administrative rules governing licensure; and

(6) adjunctive activities that may be offered by a provider entity but are not otherwise covered by medical assistance, including:

(i) a service that is primarily recreation oriented or that is provided in a setting that is not medically supervised. This includes sports activities, exercise groups, activities such as craft hours, leisure time, social hours, meal or snack time, trips to community activities, and tours;

139.1 (ii) a social or educational service that does not have or cannot reasonably be expected
139.2 to have a therapeutic outcome related to the client's mental illness;

139.3 (iii) prevention or education programs provided to the community; and

139.4 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

139.5 (b) Time spent on administrative tasks before and after providing direct services, including
139.6 scheduling or maintaining clinical records, is included in CTSS payments and may not be
139.7 separately billed as additional clock hours of service.

139.8 Sec. 45. Minnesota Statutes 2025 Supplement, section 260E.14, subdivision 1, is amended
139.9 to read:

139.10 Subdivision 1. **Facilities and schools.** (a) The local welfare agency is the agency
139.11 responsible for investigating allegations of maltreatment in child foster care, family child
139.12 care, legally nonlicensed child care, and reports involving children served by an unlicensed
139.13 personal care provider organization under section 256B.0659. Copies of findings related to
139.14 personal care provider organizations under section 256B.0659 must be forwarded to the
139.15 Department of Human Services provider enrollment.

139.16 (b) The Department of Human Services is the agency responsible for screening and
139.17 investigating allegations of maltreatment in juvenile correctional facilities listed under
139.18 section 241.021 located in the local welfare agency's county and in facilities licensed or
139.19 certified under chapters 245A and 245D.

139.20 (c) The Department of Health is the agency responsible for screening and investigating
139.21 allegations of maltreatment in facilities licensed under sections 144.50 to 144.58 and 144A.43
139.22 to 144A.482 or chapter 144H.

139.23 (d) The Department of Education is the agency responsible for screening and investigating
139.24 allegations of maltreatment in a school as defined in section 120A.05, subdivisions 9, 11,
139.25 and 13, and chapter 124E. The Department of Education's responsibility to screen and
139.26 investigate includes allegations of maltreatment involving students 18 through 21 years of
139.27 age, including students receiving special education services, up to and including graduation
139.28 and the issuance of a secondary or high school diploma.

139.29 (e) The Department of Human Services is the agency responsible for screening and
139.30 investigating allegations of maltreatment of minors in an EIDBI agency operating under
139.31 sections 245A.142 and 256B.0949.

140.1 (f) A health or corrections agency receiving a report may request the local welfare agency
140.2 to provide assistance pursuant to this section and sections 260E.20 and 260E.22.

140.3 (g) The Department of Children, Youth, and Families is the agency responsible for
140.4 screening and investigating allegations of maltreatment in facilities or programs not listed
140.5 in paragraph (a) that are licensed or certified under chapters 142B and 142C.

140.6 (h) The Department of Human Services is the agency responsible for screening and
140.7 investigating allegations of maltreatment of minors for mobile crisis response services and
140.8 children's therapeutic services and supports programs licensed under chapter 245I.

140.9 Sec. 46. Minnesota Statutes 2025 Supplement, section 626.5572, subdivision 13, is amended
140.10 to read:

140.11 Subd. 13. **Lead investigative agency.** "Lead investigative agency" is the primary
140.12 administrative agency responsible for investigating reports made under section 626.557.

140.13 (a) The Department of Health is the lead investigative agency for facilities or services
140.14 licensed or required to be licensed as hospitals, home care providers, nursing homes, boarding
140.15 care homes, hospice providers, residential facilities that are also federally certified as
140.16 intermediate care facilities that serve people with developmental disabilities, or any other
140.17 facility or service not listed in this subdivision that is licensed or required to be licensed by
140.18 the Department of Health for the care of vulnerable adults. "Home care provider" has the
140.19 meaning provided in section 144A.43, subdivision 4, and applies when care or services are
140.20 delivered in the vulnerable adult's home.

140.21 (b) The Department of Human Services is the lead investigative agency for facilities or
140.22 services licensed or required to be licensed as adult day care, adult foster care, community
140.23 residential settings, programs for people with disabilities, EIDBI agencies, family adult day
140.24 services, mental health programs licensed under chapter 245I, mental health clinics, substance
140.25 use disorder programs, the Minnesota Sex Offender Program, or any other facility or service
140.26 not listed in this subdivision that is licensed or required to be licensed by the Department
140.27 of Human Services. The Department of Human Services is also the lead investigative agency
140.28 for unlicensed EIDBI agencies under section 256B.0949. The Department of Human Services
140.29 is the lead investigative agency for adult rehabilitative mental health services under section
140.30 245I.22, mobile crisis response services under section 245I.24, and certified community
140.31 behavioral health clinics under section 245I.17.

141.1 (c) The county social service agency or its designee is the lead investigative agency for
141.2 all other reports, including but not limited to reports involving vulnerable adults receiving
141.3 services from a personal care provider organization under section 256B.0659.

141.4 **EFFECTIVE DATE.** This section is effective January 1, 2028.

141.5 Sec. 47. **REVISOR INSTRUCTION.**

141.6 The revisor of statutes shall renumber Minnesota Statutes, section 245.735, subdivisions
141.7 5 and 6, as Minnesota Statutes, section 245I.17, subdivisions 23 and 24.

141.8 Sec. 48. **REPEALER.**

141.9 (a) Minnesota Statutes 2024, sections 245.735, subdivisions 1a, 2a, 3a, 3b, 3c, 3d, 3e,
141.10 3f, 3g, 3h, 4a, 4b, 4c, 4e, 7, and 8; 245C.03, subdivision 7; 245I.20, subdivision 9; 245I.23,
141.11 subdivision 23; 256B.0623, subdivisions 2, 4, 5, 6, and 9; 256B.0624, subdivisions 2, 3,
141.12 4a, 5, 6, 6a, 6b, 7, 8, 9, and 11; and 256B.0943, subdivisions 4, 5, 5a, 6, 7, and 11, are
141.13 repealed.

141.14 (b) Minnesota Statutes 2025 Supplement, sections 245.735, subdivisions 3 and 4d; and
141.15 256B.0943, subdivisions 1 and 9, are repealed.

141.16 **EFFECTIVE DATE.** This section is effective January 1, 2028.

141.17 **ARTICLE 5**
141.18 **AGING AND DISABILITY SERVICES**

141.19 Section 1. Minnesota Statutes 2024, section 245A.03, subdivision 7, is amended to read:

141.20 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
141.21 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, which
141.22 does not include child foster residence settings with residential program certifications for
141.23 compliance with the Family First Prevention Services Act under section 245A.25, subdivision
141.24 1, paragraph (a), or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
141.25 9555.6265, under this chapter for a physical location that will not be the primary residence
141.26 of the license holder for the entire period of licensure. If a child foster residence setting that
141.27 was previously exempt from the licensing moratorium under this paragraph has its Family
141.28 First Prevention Services Act certification rescinded under section 245A.25, subdivision 9,
141.29 or if a family adult foster care home license is issued during this moratorium, and the license
141.30 holder changes the license holder's primary residence away from the physical location of
141.31 the foster care license, the commissioner shall revoke the license according to section

142.1 245A.07. The commissioner shall not issue an initial license for a community residential
142.2 setting licensed under chapter 245D. When approving an exception under this paragraph,
142.3 the commissioner shall consider the resource need determination process in paragraph (h),
142.4 the availability of foster care licensed beds in the geographic area in which the licensee
142.5 seeks to operate, the results of a person's choices during their annual assessment and service
142.6 plan review, and the recommendation of the local county board. The determination by the
142.7 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

142.8 (1) a license for a person in a foster care setting that is not the primary residence of the
142.9 license holder and where at least 80 percent of the residents are 55 years of age or older;

142.10 (2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or
142.11 community residential setting licenses replacing adult foster care licenses in existence on
142.12 December 31, 2013, and determined to be needed by the commissioner under paragraph
142.13 (b);

142.14 (3) new foster care licenses or community residential setting licenses determined to be
142.15 needed by the commissioner under paragraph (b) for the closure of a nursing facility, ICF/DD,
142.16 or regional treatment center; restructuring of state-operated services that limits the capacity
142.17 of state-operated facilities; or allowing movement to the community for people who no
142.18 longer require the level of care provided in state-operated facilities as provided under section
142.19 256B.092, subdivision 13, or 256B.49, subdivision 24;

142.20 (4) new foster care licenses or community residential setting licenses determined to be
142.21 needed by the commissioner under paragraph (b) for persons requiring hospital-level care;
142.22 or

142.23 (5) new community residential setting licenses determined necessary by the commissioner
142.24 for people affected by the closure of homes with a capacity of five or six beds currently
142.25 licensed as supervised living facilities licensed under Minnesota Rules, chapter 4665, but
142.26 not designated as intermediate care facilities. This exception is available until June 30, 2025.

142.27 (b) The commissioner shall determine the need for newly licensed foster care homes or
142.28 community residential settings as defined under this subdivision. As part of the determination,
142.29 the commissioner shall consider the availability of foster care capacity in the area in which
142.30 the licensee seeks to operate, and the recommendation of the local county board. The
142.31 determination by the commissioner must be final. A determination of need is not required
142.32 for a change in ownership at the same address.

142.33 (c) When an adult resident served by the program moves out of a foster home that is not
142.34 the primary residence of the license holder according to section 256B.49, subdivision 15,

143.1 paragraph (f), or the adult community residential setting, the county shall immediately
143.2 inform the Department of Human Services Licensing Division. The department may decrease
143.3 the statewide licensed capacity for adult foster care settings.

143.4 (d) Residential settings that would otherwise be subject to the decreased license capacity
143.5 established in paragraph (c) must be exempt if the license holder's beds are occupied by
143.6 residents whose primary diagnosis is mental illness and the license holder is certified under
143.7 the requirements in subdivision 6a or section 245D.33.

143.8 (e) A resource need determination process, managed at the state level, using the available
143.9 data required by section 144A.351, and other data and information must be used to determine
143.10 where the reduced capacity determined under section 256B.493 will be implemented. The
143.11 commissioner shall consult with the stakeholders described in section 144A.351, and employ
143.12 a variety of methods to improve the state's capacity to meet the informed decisions of those
143.13 people who want to move out of corporate foster care or community residential settings,
143.14 long-term service needs within budgetary limits, including seeking proposals from service
143.15 providers or lead agencies to change service type, capacity, or location to improve services,
143.16 increase the independence of residents, and better meet needs identified by the long-term
143.17 services and supports reports and statewide data and information.

143.18 (f) At the time of application and reapplication for licensure, the applicant and the license
143.19 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
143.20 required to inform the commissioner whether the physical location where the foster care
143.21 will be provided is or will be the primary residence of the license holder for the entire period
143.22 of licensure. If the primary residence of the applicant or license holder changes, the applicant
143.23 or license holder must notify the commissioner immediately. The commissioner shall print
143.24 on the foster care license certificate whether or not the physical location is the primary
143.25 residence of the license holder.

143.26 (g) License holders of foster care homes identified under paragraph (f) that are not the
143.27 primary residence of the license holder and that also provide services in the foster care home
143.28 that are covered by a federally approved home and community-based services waiver, as
143.29 authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human
143.30 services licensing division that the license holder provides or intends to provide these
143.31 waiver-funded services.

143.32 (h) The commissioner may adjust capacity to address needs identified in section
143.33 144A.351. Under this authority, the commissioner may approve new licensed settings or

144.1 delicense existing settings. Delicensing of settings will be accomplished through a process
144.2 identified in section 256B.493.

144.3 (i) The commissioner must notify a license holder when its corporate foster care or
144.4 community residential setting licensed beds are reduced under this section. The notice of
144.5 reduction of licensed beds must be in writing and delivered to the license holder by certified
144.6 mail or personal service. The notice must state why the licensed beds are reduced and must
144.7 inform the license holder of its right to request reconsideration by the commissioner. The
144.8 license holder's request for reconsideration must be in writing. If mailed, the request for
144.9 reconsideration must be postmarked and sent to the commissioner within 20 calendar days
144.10 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
144.11 reconsideration is made by personal service, it must be received by the commissioner within
144.12 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

144.13 (j) The commissioner shall not issue an initial license for children's residential treatment
144.14 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
144.15 for a program that Centers for Medicare and Medicaid Services would consider an institution
144.16 for mental diseases. Facilities that serve only private pay clients are exempt from the
144.17 moratorium described in this paragraph. The commissioner has the authority to manage
144.18 existing statewide capacity for children's residential treatment services subject to the
144.19 moratorium under this paragraph and may issue an initial license for such facilities if the
144.20 initial license would not increase the statewide capacity for children's residential treatment
144.21 services subject to the moratorium under this paragraph.

144.22 (k) Except as permitted in this paragraph, the commissioner must not issue an initial
144.23 license under chapter 245D authorizing integrated community supports under section
144.24 245D.03, subdivision 1, paragraph (c), clause (8), and must not approve a license change
144.25 adding integrated community supports to an existing license under chapter 245D. The
144.26 commissioner may approve an exception to the moratorium only when the applicant or
144.27 licensee meets all requirements under section 245D.12, the request is not superseded by
144.28 temporary moratoriums under section 245A.03, subdivision 7a, and the applicant submits
144.29 documentation demonstrating compliance with:

144.30 (1) federal and state home and community-based services requirements for
144.31 provider-controlled settings;

144.32 (2) the prohibition on the use of Medicaid money for room and board under section
144.33 256B.4912, subdivision 17, including the requirement that the provider not pay, subsidize,
144.34 offset, or otherwise financially contribute to rent, utilities, or other housing costs; and

145.1 (3) all licensing requirements applicable to integrated community supports under chapter
145.2 245D. In determining whether to approve an exception, the commissioner must consider
145.3 statewide and regional capacity for integrated community supports based on
145.4 needs-determination processes under paragraph (e). A determination under this paragraph
145.5 is final and not subject to appeal.

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

145.7 Sec. 2. Minnesota Statutes 2024, section 245A.042, is amended by adding a subdivision
145.8 to read:

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

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

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

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

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

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

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

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

146.15 Sec. 3. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision to
146.16 read:

146.17 Subd. 45. **Department of Human Services home and community-based services**
146.18 **provider support and technical assistance team.** The commissioner must establish and
146.19 maintain a home and community-based services provider support and technical assistance
146.20 team to deliver proactive and coordinated support to home and community-based services
146.21 providers. The commissioner must ensure that the home and community-based services
146.22 provider support and technical assistance team has sufficient staff and resources to perform
146.23 the functions required under this subdivision. The home and community-based services
146.24 provider support and technical assistance team must:

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

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

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

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

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

147.4 Sec. 4. Minnesota Statutes 2025 Supplement, section 256B.0625, subdivision 17, is
147.5 amended to read:

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

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

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

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

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

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

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

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

147.27 (d) Medical assistance covers nonemergency medical transportation provided by
147.28 nonemergency medical transportation providers enrolled in the Minnesota health care
147.29 programs. All nonemergency medical transportation providers must comply with the
147.30 operating standards for special transportation service as defined in sections 174.29 to 174.30
147.31 and Minnesota Rules, chapter 8840, and all drivers must be individually enrolled with the
147.32 commissioner and reported on the claim as the individual who provided the service. All

148.1 nonemergency medical transportation providers shall bill for nonemergency medical
148.2 transportation services in accordance with Minnesota health care programs criteria. Publicly
148.3 operated transit systems, volunteers, and not-for-hire vehicles are exempt from the
148.4 requirements outlined in this paragraph. This paragraph expires upon the effective date of
148.5 paragraph (e).

148.6 (e) Effective January 1, 2027, or upon federal approval, whichever is later, medical
148.7 assistance covers nonemergency medical transportation provided by nonemergency medical
148.8 transportation providers enrolled in the Minnesota health care programs. All nonemergency
148.9 medical transportation providers must comply with the operating standards for special
148.10 transportation service as defined in sections 174.29 to 174.30 and Minnesota Rules, chapter
148.11 8840, and all drivers must be individually enrolled with the commissioner and reported on
148.12 the claim as the individual who provided the service. All nonemergency medical
148.13 transportation providers must bill for nonemergency medical transportation services in
148.14 accordance with Minnesota health care programs criteria and comply with the requirements
148.15 of section 256B.073. Publicly operated transit systems, volunteers, and not-for-hire vehicles
148.16 are exempt from the requirements outlined in this paragraph.

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

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

148.20 (2) the provider has initiated background studies on the individuals specified in section
148.21 174.30, subdivision 10, paragraph (a), clauses (1) to (3), and:

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

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

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

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

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

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

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

~~(g)~~ (h) Effective July 1, 2026, for medical fee-for-service and January 1, 2027, for prepaid medical assistance, the administrative agency of nonemergency medical transportation must:

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

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

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

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

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

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

150.1 ~~(k)~~ (l) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027,
150.2 for prepaid medical assistance, nonemergency medical transportation providers must take
150.3 clients to the health care provider using the most direct route and must not exceed 30 miles
150.4 for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless
150.5 the client receives authorization from the administrator.

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

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

150.17 ~~(n)~~ (o) The covered modes of transportation are:

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

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

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

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

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

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

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

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

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

~~(p)~~ (q) The commissioner shall:

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

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

(3) investigate all complaints and appeals.

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

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

(1) $0.22 per mile for client reimbursement;

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

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

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

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

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

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

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

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

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

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

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

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

~~(w)~~ (x) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00

153.1 per gallon, the commissioner shall adjust the rate paid per mile in paragraph ~~(r)~~ (s) by one
153.2 percent up or down for every increase or decrease of ten cents for the price of gasoline. The
153.3 increase or decrease must be calculated using a base gasoline price of $3.00. The percentage
153.4 increase or decrease must be calculated using the average of the most recently available
153.5 price of all grades of gasoline for Minnesota as posted publicly by the United States Energy
153.6 Information Administration. This paragraph expires July 1, 2026, for medical assistance
153.7 fee-for-service and January 1, 2027, for prepaid medical assistance.

153.8 Sec. 5. Minnesota Statutes 2024, section 256B.0625, subdivision 17b, is amended to read:

153.9 Subd. 17b. **Documentation required.** (a) As a condition for payment, nonemergency
153.10 medical transportation providers must document each occurrence of a service provided to
153.11 a recipient according to this subdivision. Providers must maintain records sufficient to
153.12 distinguish individual trips with specific vehicles and drivers. The documentation may be
153.13 collected and maintained using electronic systems or software or in paper form but must be
153.14 made available and produced upon request. Program funds paid for transportation that is
153.15 not documented according to this subdivision may be subject to recovery by the commissioner
153.16 pursuant to section 256B.064.

153.17 (b) A nonemergency medical transportation provider must compile transportation trip
153.18 records that are written in English and legible according to the standard of a reasonable
153.19 person and that include each of the following elements:

153.20 (1) the recipient's name;

153.21 (2) the date or dates the service is provided, if different than the date the entry was made;

153.22 (3) either the printed name of the driver sufficient to distinguish the driver of service or
153.23 the driver's provider number;

153.24 (4) the date and the signature of the driver attesting that the record accurately represents
153.25 the services provided and the actual miles driven, and acknowledging that misreporting
153.26 information that results in ineligible or excessive payments may result in civil or criminal
153.27 action;

153.28 (5) the date and the signature of the recipient or authorized party attesting that
153.29 transportation services were provided as indicated on the transportation trip record, or the
153.30 signature of the medical services provider certifying that the recipient was transported to
153.31 the medical services provider destination. In the event that both the medical services provider
153.32 and the recipient or authorized party refuse or are unable to provide signatures, the driver

154.1 must document on the transportation trip record that signatures were requested and not
154.2 provided;

154.3 (6) the address, or the description if the address is not available, of both the origin and
154.4 destination, and the mileage for the most direct route from the origin to the destination;

154.5 (7) the name or number of the mode of transportation in which the service is provided;

154.6 (8) the license plate number of the vehicle used to transport the recipient;

154.7 (9) the time of the recipient pickup;

154.8 (10) the time of the recipient drop-off;

154.9 (11) the odometer reading of the vehicle used to transport the recipient taken at the time
154.10 of pickup;

154.11 (12) the odometer reading of the vehicle used to transport the recipient taken at the time
154.12 of drop-off;

154.13 (13) the name of the extra attendant when an extra attendant is used to provide special
154.14 transportation service; and

154.15 (14) the documentation indicating the method that was used to determine the most direct
154.16 route.

154.17 (c) In determining whether the commissioner will seek recovery, the documentation
154.18 requirements in this section apply retroactively to audit findings beginning January 1, 2020,
154.19 and to all audit findings thereafter.

154.20 (d) Effective January 1, 2027, or upon federal approval, whichever is later, records that
154.21 comply with section 256B.073 may be used to meet the requirements of this subdivision if
154.22 all required elements are included in the record.

154.23 Sec. 6. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision
154.24 to read:

154.25 Subd. 77. **Early intensive developmental and behavioral intervention benefit.** Medical
154.26 assistance covers early intensive developmental and behavioral intervention services
154.27 according to section 256B.0949.

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

Sec. 7. Minnesota Statutes 2024, section 256B.073, subdivision 1, is amended to read:

Subdivision 1. **Documentation; establishment and operation.** The commissioner of human services shall establish ~~implementation requirements and standards for~~ and maintain the requirements and standards for the ongoing operation of electronic visit verification to comply with the 21st Century Cures Act, Public Law 114-255. Within available appropriations, the commissioner shall take steps to comply with the electronic visit verification requirements in the 21st Century Cures Act, Public Law 114-255.

Sec. 8. Minnesota Statutes 2024, section 256B.073, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms in this subdivision have the meanings given ~~them~~.

(b) "Data aggregator" means the entity designated by the commissioner to collect, store, and transmit electronic visit verification data from providers and third-party systems to the commissioner in accordance with the standards and requirements established under this section.

~~(b)~~ (c) "Electronic visit verification" or "EVV" means the ~~electronic documentation of the~~ process required under United States Code, title 42, section 1396b(l), and this section used to electronically verify the:

(1) type of service performed;

(2) individual receiving the service;

(3) date of the service;

(4) location of the service delivery;

(5) individual providing the service; ~~and~~

(6) time the service begins and ends; and

(7) method by which the service recipient, the service recipient's legal guardian or conservator, or the service recipient's parent, if the service recipient is a minor, attests to the accuracy of the information contained on the electronic visit verification.

(d) "Electronic visit verification data" means information collected through an electronic visit verification system, including data elements required under United States Code, title 42, section 1396b(l), and any additional data elements specified by the commissioner under this section.

156.1 ~~(c)~~ (e) "Electronic visit verification system" means a system ~~that provides electronic~~
156.2 ~~verification of services~~ used to collect, verify, and transmit electronic visit verification data
156.3 to the commissioner or the commissioner's designated data aggregator that complies with
156.4 the 21st Century Cures Act, Public Law 114-255, and the requirements of subdivision 3.

156.5 (1) is enrolled as a Minnesota health care programs provider;

156.6 (2) provides services through a managed care organization under contract with the
156.7 commissioner under section 256B.69;

156.8 (3) is a financial management services provider; or

156.9 (4) is a participant employer under section 256B.85, subdivision 7, or an employer of
156.10 record directing services under section 256B.49, subdivision 16.

156.11 (f) "Electronic visit verification vendor" means any entity that develops, provides, or
156.12 supports an electronic visit verification system, including the state-provided vendor and
156.13 any third-party vendor.

156.14 (g) "Financial management services provider" means an entity enrolled with the
156.15 commissioner to provide financial management services under section 256B.85 or other
156.16 applicable law and responsible for fiscal, payroll, and reporting functions on behalf of
156.17 participant employers.

156.18 (h) "Home health agency" means a home care provider agency that is Medicare certified
156.19 under Code of Federal Regulations, title 42, part 484, and licensed as a home care provider
156.20 under chapter 144A.

156.21 (i) "Individual" means a person who receives services subject to electronic visit
156.22 verification under the medical assistance program.

156.23 (j) "Managed care organization" means a public or private organization that contracts
156.24 with the commissioner under section 256B.69 or other applicable law to deliver health care
156.25 services to individuals eligible for medical assistance or MinnesotaCare.

156.26 (k) "Manual visit" means a visit:

156.27 (1) entered administratively and not by the caregiver at the time of service delivery; or

156.28 (2) where data elements are edited after the time of service delivery.

156.29 (l) "Provider" means an individual or organization that meets one or more of the following
156.30 conditions:

156.31 (1) is enrolled as a Minnesota health care programs provider;

157.1 (2) provides services through a managed care organization under contract with the
157.2 commissioner under section 256B.69;

157.3 (3) is a financial management services provider; or

157.4 (4) is a participant employer under section 256B.85, subdivision 7, or an employer of
157.5 record directing services under section 256B.49, subdivision 16.

157.6 ~~(d)~~ (m) "Service" means one of the following:

157.7 (1) personal care assistance services as defined in section 256B.0625, subdivision 19a,
157.8 and provided according to section 256B.0659;

157.9 (2) community first services and supports under section 256B.85;

157.10 (3) home health services under section 256B.0625, subdivision 6a; ~~or~~

157.11 (4) adult companion services adult day services;

157.12 (5) adult rehabilitative mental health services;

157.13 (6) assertive community treatment;

157.14 (7) early intensive developmental and behavioral intervention;

157.15 (8) integrated community supports;

157.16 (9) nonemergency medical transportation services;

157.17 (10) recovery peer support;

157.18 (11) recuperative care;

157.19 (12) home and community-based services reimbursed at an hourly or specified
157.20 minute-based rate and provided according to a federally approved waiver plan as authorized
157.21 under chapter 256S or section 256B.0913, 256B.092, or 256B.49; or

157.22 (13) other medical supplies and equipment or home and community-based services that
157.23 are required to be electronically verified by the 21st Century Cures Act, Public Law 114-255.

157.24 (o) "State-provided electronic visit verification system" means the electronic visit
157.25 verification system made available by the commissioner to providers at no cost for services
157.26 subject to federal electronic visit verification requirements.

157.27 (p) "Third-party electronic visit verification system" means an electronic visit verification
157.28 system purchased or operated by a provider or vendor other than the state-provided system
157.29 designated by the commissioner.

158.1 (q) "Verification method" means the electronic process used to capture and verify visit
158.2 information, including telephone, fixed visit verification devices, or mobile applications,
158.3 as approved by the commissioner.

158.4 (r) "Visit" means a single occurrence of service delivery subject to electronic visit
158.5 verification.

158.6 (s) "Worker" means an individual who provides personal care assistance services,
158.7 community first services and supports, home health services, consumer-directed community
158.8 supports, or other services identified by the commissioner as subject to electronic visit

158.9 Sec. 9. Minnesota Statutes 2024, section 256B.073, subdivision 3, is amended to read:

158.10 Subd. 3. **Requirements.** (a) In developing implementation requirements for administering
158.11 electronic visit verification, the commissioner shall must ensure that the system and related
158.12 requirements:

158.13 (1) are minimally administratively and financially burdensome to a provider reasonable
158.14 for providers of services;

158.15 (2) are minimally burdensome support continued access to the services and are designed
158.16 to avoid disruption to service recipient and the least disruptive to the service recipient in
158.17 receiving and maintaining allowed services delivery or receipt;

158.18 (3) consider existing best practices and use of electronic visit verification;

158.19 (4) are conducted according to all state and federal laws;

158.20 (5) are effective methods for preventing fraud when balanced against the requirements
158.21 of clauses (1) and (2); and

158.22 (6) are consistent with the Department of Human Services' policies related to covered
158.23 services, flexibility of service use, and quality assurance.

158.24 (b) The commissioner shall must make training and guidance available to providers of
158.25 services on the electronic visit verification system requirements and system use.

158.26 (c) The commissioner shall must establish baseline measurements related to preventing
158.27 fraud and establish measures to determine the effect of electronic visit verification
158.28 requirements on program integrity.

158.29 (d) The commissioner shall must make a state-selected state-provided electronic visit
158.30 verification system available to providers of services.

159.1 (e) The commissioner ~~shall~~ must make available and publish on the agency website the
159.2 name and contact information for the vendor of the ~~state-selected~~ state-provided electronic
159.3 visit verification system and the other vendors that offer alternative electronic visit
159.4 verification systems. The information provided must state that the ~~state-selected~~
159.5 state-provided electronic visit verification system is offered at no cost to the provider of
159.6 services and that the provider of service may choose an alternative system that may be at a
159.7 cost to the provider.

159.8 (f) The commissioner may establish implementation dates and implementation schedules
159.9 for system functions subject to electronic visit verification under this section, including but
159.10 not limited to verification methods or technical requirements.

159.11 (g) The commissioner may waive the requirements of this section for any service
159.12 component or setting when the application of electronic visit verification is contrary to
159.13 paragraph (a).

159.14 Sec. 10. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
159.15 to read:

159.16 Subd. 4a. **Electronic visit verification system options.** (a) A provider of services must
159.17 use an electronic visit verification system that complies with the requirements established
159.18 by the commissioner. A provider of services may use either the state-provided system or a
159.19 third-party system. All systems used for compliance must provide data to the commissioner
159.20 in the format and frequency required by the commissioner.

159.21 (b) The commissioner must make a state-provided electronic visit verification system
159.22 available at no cost to providers of services. The commissioner must provide training on
159.23 the system to all providers of services.

159.24 (c) The commissioner must allow providers of services to utilize a third-party electronic
159.25 visit verification system that the commissioner determines meets the requirements of this
159.26 section.

159.27 (d) A provider of services using a third-party electronic visit verification system that
159.28 meets all technical specifications and federal and state laws must:

159.29 (1) collect and submit all data for each visit to the commissioner, including but not
159.30 limited to manual entries;

159.31 (2) maintain compliance identified by the commissioner, including but not limited to
159.32 incorporating into the system any changes in data requirements that must be transmitted to
159.33 the commissioner; and

160.1 (3) integrate the system with the data aggregator to accurately send data.

160.2 (e) The data aggregator must be available at no cost to a provider of services for purposes
160.3 of transmitting electronic visit verification data from approved third-party systems to the
160.4 commissioner. Any costs associated with the development and use of a third-party system
160.5 are the responsibility of the provider.

160.6 (f) If a provider is unable to integrate a third-party system with the data aggregator, the
160.7 provider of service must use the state-provided electronic visit verification system.

160.8 (g) The commissioner must provide training on reviewing and correcting imported data
160.9 in the data aggregator to providers of services.

160.10 Sec. 11. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
160.11 to read:

160.12 Subd. 4b. **Provider responsibilities.** A provider of services must:

160.13 (1) use an electronic visit verification system that meets all technical and data submission
160.14 requirements established by the commissioner;

160.15 (2) enroll with the state-provided electronic visit verification system or the data
160.16 aggregator, as applicable;

160.17 (3) provide all information requested by the commissioner for enrollment, access, and
160.18 data submission and ensure that such information remains accurate and up to date;

160.19 (4) maintain records for each individual receiving services subject to electronic visit
160.20 verification, including but not limited to all required data elements;

160.21 (5) maintain a current list of workers providing services subject to electronic visit
160.22 verification to individuals receiving services under medical assistance;

160.23 (6) provide the commissioner and any managed care organization with immediate, direct,
160.24 and on-site or remote access to the electronic visit verification system;

160.25 (7) at the request of the commissioner or a managed care organization, allow review or
160.26 copying of electronic visit verification documentation at no cost;

160.27 (8) ensure that electronic visit verification systems and related processes meet accessibility
160.28 and confidentiality requirements under state and federal law;

160.29 (9) comply with all policies, procedures, and technical specifications issued by the
160.30 commissioner under this section; and

(10) ensure that workers, participants, and other individuals using electronic visit verification are trained and comply with all documentation and data entry requirements established by the commissioner.

Sec. 12. Minnesota Statutes 2024, section 256B.073, subdivision 5, is amended to read:

Subd. 5. **Vendor requirements.** (a) The vendor of the electronic visit verification system ~~selected~~ provided by the commissioner and the vendor's affiliate must comply with the requirements of this subdivision.

(b) The vendor of the ~~state-selected~~ state-provided electronic visit verification system and the vendor's affiliate must:

(1) notify the provider of services that the provider may choose the ~~state-selected~~ state-provided electronic visit verification system at no cost to the provider;

(2) offer the ~~state-selected~~ state-provided electronic visit verification system to the provider of services prior to offering any fee-based electronic visit verification system;

(3) notify the provider of services that the provider may choose any fee-based electronic visit verification system prior to offering the vendor's or its affiliate's fee-based electronic visit verification system; and

(4) when offering the ~~state-selected~~ state-provided electronic visit verification system, clearly differentiate between the ~~state-selected~~ state-provided electronic visit verification system and the vendor's or its affiliate's alternative fee-based system.

(c) The vendor of the ~~state-selected~~ state-provided electronic visit verification system and the vendor's affiliate must not use state data that are not available to other vendors of electronic visit verification systems to promote or sell the vendor's or its affiliate's alternative electronic visit verification system.

(d) Upon request from the provider, the vendor of the ~~state-selected~~ state-provided electronic visit verification system must provide proof of compliance with the requirements of paragraph (b).

(e) An agreement between the vendor of the ~~state-selected~~ state-provided electronic visit verification system or its affiliate and a provider of services for an electronic visit verification system that is not the ~~state-selected~~ state-provided system entered into on or after July 1, 2023, is subject to immediate termination by the provider if the vendor violates any of the requirements of paragraph (b).

162.1 Sec. 13. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
162.2 to read:

162.3 Subd. 6. **Data and documentation.** (a) A provider of services must submit electronic
162.4 visit verification data to the commissioner or the data aggregator in accordance with the
162.5 technical standards, format, and frequency established under this section. The commissioner
162.6 may use integrated electronic visit verification data for oversight, quality assurance, and
162.7 program integrity purposes consistent with state and federal law.

162.8 (b) The commissioner and managed care organizations must use electronic visit
162.9 verification data to validate claims for payment under medical assistance. Claims that cannot
162.10 be validated in accordance with electronic visit verification requirements may be subject
162.11 to actions by the commissioner as authorized under state and federal law, including actions
162.12 related to payment, program integrity, or provider compliance.

162.13 (c) A provider of services must record all required electronic visit verification data at
162.14 the time of service delivery using an approved verification method. To be compliant with
162.15 electronic visit verification requirements, a provider of services must document a visit with
162.16 all required data elements recorded at the time of service delivery.

162.17 (d) A manual visit does not comply with electronic visit verification requirements. A
162.18 manual visit must be confirmed and verified according to processes established by the
162.19 commissioner before being used to validate or support a claim for payment.

162.20 (e) A worker providing services subject to electronic visit verification must record the
162.21 start and end times of each visit at the time the service is delivered using an approved
162.22 verification method. A worker must complete and verify all time documentation, including
162.23 but not limited to verification of service type, date, and duration, on the date the service
162.24 occurs and be consistent with documentation requirements of the service being provided.
162.25 A provider of services must maintain documentation demonstrating compliance with this
162.26 subdivision and make the documentation available to the commissioner or a managed care
162.27 organization upon request.

162.28 Sec. 14. Minnesota Statutes 2024, section 256B.073, is amended by adding a subdivision
162.29 to read:

162.30 Subd. 7. **Third-party system responsibilities.** (a) This subdivision is effective for Early
162.31 Intensive Developmental and Behavioral Intervention services beginning July 1, 2027, or
162.32 upon federal approval, whichever is later. This subdivision is effective for all other services

163.1 subject to this subdivision beginning January 1, 2027, or upon federal approval, whichever
163.2 is later.

163.3 (b) A provider of services using a third-party electronic visit verification system must
163.4 ensure that the system meets all technical, functional, and data-exchange requirements
163.5 established by the commissioner and transmits data to the commissioner or the data
163.6 aggregator in the format and frequency required by the commissioner.

163.7 (c) A third-party electronic visit verification vendor must:

163.8 (1) comply with all technical, contractual, privacy, and security standards established
163.9 by the commissioner;

163.10 (2) not use or disclose state data for any purpose other than fulfilling the requirements
163.11 of this section or federal law;

163.12 (3) provide the commissioner access to system documentation, data mapping, and audit
163.13 records upon request; and

163.14 (4) immediately report to the commissioner any data transmission failure, breach, or
163.15 interruption affecting the commissioner's ability to receive required electronic visit
163.16 verification data.

163.17 (d) A provider of services remains responsible for ensuring compliance with this section
163.18 even when using a third-party electronic visit verification system.

163.19 (e) The third-party vendor must ensure training on the system is available to providers
163.20 of services.

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

163.22 Sec. 15. Minnesota Statutes 2024, section 256B.0911, subdivision 32, is amended to read:

163.23 Subd. 32. **Administrative activity.** (a) The commissioner shall:

163.24 (1) streamline the processes, including timelines for when assessments need to be
163.25 completed;

163.26 (2) provide the services in this section; ~~and~~

163.27 (3) implement integrated solutions to automate the business processes to the extent
163.28 necessary for support plan approval, reimbursement, program planning, evaluation, and
163.29 policy development~~.~~; and

163.30 (4) grant limited role-based access to a person's support plan in the MnCHOICES system
163.31 to home and community-based service providers who have been designated as a provider

164.1 for that person by a lead agency for the purpose of signing the person's support plan
164.2 electronically and demonstrating that the provider has reviewed, understood, and agrees to
164.3 deliver services as outlined in the plan.

164.4 (b) The commissioner shall work with lead agencies responsible for conducting long-term
164.5 care consultation services to:

164.6 (1) modify the MnCHOICES application and assessment policies to create efficiencies
164.7 while ensuring federal compliance with medical assistance and long-term services and
164.8 supports eligibility criteria; and

164.9 (2) develop a set of measurable benchmarks sufficient to demonstrate quarterly
164.10 improvement in the average time per assessment and other mutually agreed upon measures
164.11 of increasing efficiency.

164.12 (c) The commissioner shall collect data on the benchmarks developed under paragraph
164.13 (b) and provide to the lead agencies an annual trend analysis of the data in order to
164.14 demonstrate the commissioner's compliance with the requirements of this subdivision.

164.15 Sec. 16. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 2, is
164.16 amended to read:

164.17 Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this
164.18 subdivision.

164.19 (b) "Advanced certification" means a person who has completed advanced certification
164.20 in an approved modality under subdivision 13, paragraph (b).

164.21 (c) "Agency" means the legal entity that is enrolled with Minnesota health care programs
164.22 as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide
164.23 EIDBI services and that has the legal responsibility to ensure that its employees carry out
164.24 the responsibilities defined in this section. Agency includes a licensed individual professional
164.25 who practices independently and acts as an agency.

164.26 (d) "Autism spectrum disorder or a related condition" or "ASD or a related condition"
164.27 means either autism spectrum disorder (ASD) as defined in the current version of the
164.28 Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found
164.29 to be closely related to ASD, as identified under the current version of the DSM, and meets
164.30 all of the following criteria:

164.31 (1) is severe and chronic;

165.1 (2) results in impairment of adaptive behavior and function similar to that of a person
165.2 with ASD;

165.3 (3) requires treatment or services similar to those required for a person with ASD; and

165.4 (4) results in substantial functional limitations in three core developmental deficits of
165.5 ASD: social or interpersonal interaction; functional communication, including nonverbal
165.6 or social communication; and restrictive or repetitive behaviors or hyperreactivity or
165.7 hyporeactivity to sensory input; and may include deficits or a high level of support in one
165.8 or more of the following domains:

165.9 (i) behavioral challenges and self-regulation;

165.10 (ii) cognition;

165.11 (iii) learning and play;

165.12 (iv) self-care; or

165.13 (v) safety.

165.14 (e) "Behavior analyst" means an individual licensed under sections 148.9981 to 148.9995
165.15 as a behavior analyst.

165.16 (f) "Clinical supervision" means the overall responsibility for the control and direction
165.17 of EIDBI service delivery, including ~~individual treatment planning,~~ staff supervision,
165.18 including observation and direction; individual treatment plan development and progress
165.19 monitoring~~,~~; family training and counseling; and ~~treatment review~~ coordinated care
165.20 conference coordination for each person. Clinical supervision is provided by a qualified
165.21 supervising professional (QSP) who takes full professional responsibility for the service
165.22 provided by each supervisee and the clinical effectiveness of all interventions.

165.23 (g) "Commissioner" means the commissioner of human services, unless otherwise
165.24 specified.

165.25 (h) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive
165.26 evaluation of a person to determine medical necessity for EIDBI services based on the
165.27 requirements in subdivision 5.

165.28 (i) "Department" means the Department of Human Services, unless otherwise specified.

165.29 (j) "Early intensive developmental and behavioral intervention benefit" or "EIDBI
165.30 benefit" means a variety of individualized, intensive treatment modalities approved and
165.31 published by the commissioner that are based in behavioral and developmental science
165.32 consistent with best practices on effectiveness.

166.1 (k) "Employee of an agency" or "employee" means any individual who is employed
166.2 temporarily, part time, or full time by the agency that is submitting claims or billing for the
166.3 work, services, supervision, or treatment performed by the individual. Employee does not
166.4 include an independent contractor, billing agency, or consultant who is not providing EIDBI
166.5 services. Employee does not include an individual who performs work, provides services,
166.6 supervises, or provides treatment for less than 80 hours in a 12-month period.

166.7 (l) "Generalizable goals" means results or gains that are observed during a variety of
166.8 activities over time with different people, such as providers, family members, other adults,
166.9 and people, and in different environments including, but not limited to, clinics, homes,
166.10 schools, and the community.

166.11 (m) "Incident" means when any of the following occur:

166.12 (1) an illness, accident, or injury that requires first aid treatment;

166.13 (2) a bump or blow to the head; or

166.14 (3) an unusual or unexpected event that jeopardizes the safety of a person or staff,
166.15 including a person leaving the agency unattended.

166.16 (n) "Individual treatment plan" or "ITP" means the person-centered, individualized
166.17 written plan of care that integrates and coordinates person and family information from the
166.18 CMDE for a person who meets medical necessity for the EIDBI benefit. An individual
166.19 treatment plan must meet the standards in subdivision 6.

166.20 (o) "Legal representative" means the parent of a child who is under 18 years of age, a
166.21 court-appointed guardian, or other representative with legal authority to make decisions
166.22 about service for a person. For the purpose of this subdivision, "other representative with
166.23 legal authority to make decisions" includes a health care agent or an attorney-in-fact
166.24 authorized through a health care directive or power of attorney.

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

166.27 (q) "Person" means an individual under 21 years of age.

166.28 (r) "Person-centered" means a service that both responds to the identified needs, interests,
166.29 values, preferences, and desired outcomes of the person or the person's legal representative
166.30 and respects the person's history, dignity, and cultural background and allows inclusion and
166.31 participation in the person's community.

167.1 (s) "Qualified EIDBI provider" means an individual who is a QSP or a level I, level II,
167.2 or level III treatment provider.

167.3 Sec. 17. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is
167.4 amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

169.9 Sec. 18. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision
169.10 to read:

169.11 Subd. 19. **Documentation requirements.** (a) CMDE and EIDBI providers must ensure
169.12 that all documentation, including but not limited to health service records and personnel
169.13 files, complies with this subdivision, subdivision 16, and Minnesota Rules, parts 9505.2175
169.14 and 9505.2197. Documentation must be complete, legible, accurate, and readily accessible.

169.15 (b) All documentation must:

169.16 (1) be legible and understandable to individuals outside service delivery;

169.17 (2) include the participant's name on each health record page and the provider's name
169.18 on each personnel file page;

169.19 (3) be signed and dated by the provider completing the documentation, with the provider's
169.20 full name, title, and credentials;

169.21 (4) be entered within 72 hours of service, and contain a record and explanation of any
169.22 delays in entry;

169.23 (5) clearly reflect clinical decision-making and support medical necessity;

169.24 (6) be securely stored in accordance with the Health Insurance Portability and
169.25 Accountability Act (HIPAA), Public Law 104-191;

169.26 (7) be stored in accordance with state and federal document retention laws;

169.27 (8) be available for review or audit;

169.28 (9) include a record of caregiver involvement where applicable; and

169.29 (10) include a record of supervision and oversight for staff providing services requiring
169.30 supervision under EIDBI policy.

170.1 (c) Each EIDBI service occurrence must be documented in a progress note in a manner
170.2 and with the information determined by the commissioner.

170.3 (d) All providers must maintain current personnel records for each employee in a manner
170.4 determined by the commissioner that include:

170.5 (1) the employee's name, contact information, and hire date;

170.6 (2) the employee's completed employment application and acknowledgment of duties;

170.7 (3) the job description for the employee's job with the effective date;

170.8 (4) verification of the employee's qualifications, including but not limited to education,
170.9 licenses, certifications, enrollment attestation, degrees, transcripts, and experience;

170.10 (5) a background check pursuant to chapter 245C;

170.11 (6) orientation and required training the employee attended, including but not limited
170.12 to training on mandated reporting, cultural responsiveness, and EIDBI competencies;

170.13 (7) the dates of the employee's first supervised and unsupervised client contact following
170.14 employment;

170.15 (8) documentation of supervision received by the employee, including but not limited
170.16 to the supervisor's name and credentials, dates of supervision, and supervision content;

170.17 (9) the employee's CPR and emergency response training, if required; and

170.18 (10) the employee's annual performance evaluations.

170.19 Sec. 19. Minnesota Statutes 2024, section 256B.4905, subdivision 11, is amended to read:

170.20 Subd. 11. **Informed choice in technology policy.** It is the policy of this state that all
170.21 adults who have disabilities and children who have disabilities:

170.22 (1) can use assistive technology, remote supports, or a combination of both to enhance
170.23 the adult's or child's independence and quality of life; and

170.24 (2) have the right, at least annually, to make an informed choice about the adult's or
170.25 child's use of assistive technology and remote supports when permitted under the individual's
170.26 federally approved waiver plan, service authorization, and applicable service standards.

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

Sec. 20. Minnesota Statutes 2024, section 256B.4905, subdivision 12, is amended to read:

Subd. 12. **Informed choice and technology prioritization in implementation for disability waiver services.** (a) The commissioner of human services shall ensure that:

(1) disability waivers under sections 256B.092 and 256B.49 support the presumption that all adults who have disabilities and children who have disabilities may use assistive technology, remote supports, or both to enhance the adult's or child's independence and quality of life; ~~and~~

(2) each individual accessing waiver services is offered, after an informed decision-making process and during a person-centered planning process, the opportunity to choose assistive technology, remote support, or both prior to the commissioner offering or reauthorizing services that utilize direct support staff to ensure equitable access~~.~~; and

(3) policies and procedures related to the use of technology, including but not limited to remote support, promote informed choice and protect the health and safety of individuals receiving services consistent with federal law and the terms of approved waiver plans.

(b) Nothing in this subdivision authorizes the use of remote support as a method of service delivery unless expressly permitted under the applicable service definition, waiver plan, and service standards approved by the Centers for Medicare and Medicaid Services.

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

Sec. 21. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision to read:

Subd. 10a. **Individual provider identifier.** (a) Effective January 1, 2027, staff that provide direct contact, as defined in section 245C.02, subdivision 11, for services specified in the federally approved waiver plans must enroll individually with Minnesota health care programs as a medical assistance provider. This requirement also applies to consumer-directed community supports.

(b) For individuals enrolling individually under this subdivision, the commissioner must conform with the requirements of section 256B.0444, subdivision 3.

Sec. 22. Minnesota Statutes 2024, section 256B.4912, subdivision 12, is amended to read:

Subd. 12. **Home and community-based service documentation requirements.** (a) Unless the provider is required to use an electronic visit verification system authorized under section 256B.073, the provider must collect and maintain documentation ~~may be~~

172.1 ~~collected and maintained~~ electronically or in paper form ~~by providers and must be produced~~.
172.2 The provider must produce all documentation upon request by the commissioner.

172.3 (b) Documentation of a delivered service must be in English and must be legible according
172.4 to the standard of a reasonable person.

172.5 (c) If the service is reimbursed at an hourly or specified minute-based rate, each
172.6 documentation of the provision of a service, unless otherwise specified, must include:

172.7 (1) the date the documentation occurred;

172.8 (2) the day, month, and year when the service was provided;

172.9 (3) the start and stop times with a.m. and p.m. designations, except for case management
172.10 services as defined under chapter 256S and sections 256B.0913, subdivision 7; 256B.092,
172.11 subdivision 1a; and 256B.49, subdivision 13;

172.12 (4) the service name or description of the service provided; and

172.13 (5) the name, individual provider identifier, signature, and title, if any, of the provider
172.14 of service. If the service is provided by multiple staff members, the provider may designate
172.15 a staff member responsible for verifying services and completing the documentation required
172.16 by this paragraph.

172.17 (d) If the service is reimbursed at a daily rate or does not meet the requirements in
172.18 paragraph (c), each documentation of the provision of a service, unless otherwise specified,
172.19 must include:

172.20 (1) the date the documentation occurred;

172.21 (2) the day, month, and year when the service was provided;

172.22 (3) the service name or description of the service provided; and

172.23 (4) the name, individual provider identifier, signature, and title, if any, of the person
172.24 providing the service. If the service is provided by multiple staff, the provider may designate
172.25 a staff member responsible for verifying services and completing the documentation required
172.26 by this paragraph. The designated staff member verifying the services must include in the
172.27 documentation of the provision of a service the names and individual provider identifiers
172.28 of all staff who provided the service.

172.29 Sec. 23. Minnesota Statutes 2024, section 256B.4912, subdivision 14, is amended to read:

172.30 Subd. 14. **Equipment and supply documentation requirements.** (a) ~~In addition to~~ An
172.31 equipment and supply services provider must follow the requirements in subdivision 12,

173.1 except for the requirement to provide an individual provider identifier. An equipment and
173.2 supply services provider must also include for each documentation of the provision of a
173.3 service ~~include~~:

173.4 (1) the recipient's assessed need for the equipment or supply;

173.5 (2) the reason the equipment or supply is not covered by the Medicaid state plan;

173.6 (3) the type and brand name of the equipment or supply delivered to or purchased by
173.7 the recipient, including whether the equipment or supply was rented or purchased;

173.8 (4) the quantity of the equipment or supply delivered or purchased; and

173.9 (5) the cost of the equipment or supply if the amount paid for the service depends on
173.10 the cost.

173.11 (b) A provider must maintain a copy of the shipping invoice or a delivery service tracking
173.12 log or other documentation showing the date of delivery that proves the equipment or supply
173.13 was delivered to the recipient or a receipt if the equipment or supply was purchased by the
173.14 recipient.

173.15 Sec. 24. Minnesota Statutes 2024, section 256B.4912, subdivision 15, is amended to read:

173.16 Subd. 15. **Adult day service documentation and billing requirements.** (a) In addition
173.17 to the requirements in subdivision 12, a provider of adult day services as defined in section
173.18 245A.02, subdivision 2a, and licensed under Minnesota Rules, parts 9555.9600 to 9555.9730,
173.19 must maintain documentation of:

173.20 (1) a needs assessment and current plan of care according to section 245A.143,
173.21 subdivisions 4 to 7, or Minnesota Rules, part 9555.9700, for each recipient, if applicable;

173.22 (2) attendance records as specified under section 245A.14, subdivision 14, paragraph
173.23 (a), including the date of attendance with the day, month, and year; and the pickup and
173.24 drop-off time in hours and minutes with a.m. and p.m. designations;

173.25 (3) the monthly and quarterly program requirements in Minnesota Rules, part 9555.9710,
173.26 subparts 1, items E and H; 3; 4; and 6, if applicable;

173.27 (4) the name, individual provider identifier, and qualification of each registered physical
173.28 therapist, registered nurse, and registered dietitian who provides services to the adult day
173.29 services or nonresidential program; and

173.30 (5) the location where the service was provided. If the location is an alternate location
173.31 from the usual place of service, the documentation must include the address, or a description

174.1 if the address is not available, of both the origin site and destination site; the length of time
174.2 at the alternate location with a.m. and p.m. designations; and a list of participants who went
174.3 to the alternate location.

174.4 (b) A provider must not exceed the provider's licensed capacity. If a provider exceeds
174.5 the provider's licensed capacity, the ~~department~~ commissioner must recover all Minnesota
174.6 health care programs payments from the date the provider exceeded licensed capacity.

174.7 Sec. 25. Minnesota Statutes 2024, section 256B.4912, is amended by adding a subdivision
174.8 to read:

174.9 Subd. 17. **Prohibition on room and board payments.** (a) The provider must not use
174.10 medical assistance money to pay for room and board, including but not limited to rent,
174.11 mortgage payments, utilities, property taxes, homeowners association fees, or any other
174.12 housing-related cost, in accordance with federal home and community-based services waiver
174.13 requirements under United States Code, title 42, section 1396n(c), and Code of Federal
174.14 Regulations, title 42, section 441.310.

174.15 (b) A provider of home and community-based services, including but not limited to
174.16 integrated community supports under section 245D.03, subdivision 1, paragraph (c), clause
174.17 (8), must not:

174.18 (1) use, allocate, or apply any payment for home and community-based services to cover,
174.19 subsidize, discount, or otherwise contribute to any room and board expenses for a person
174.20 receiving services;

174.21 (2) apply agency operating margins, reserves, or profits derived from home and
174.22 community-based services to pay for rent or pay other housing costs for persons receiving
174.23 services; or

174.24 (3) enter into any financial arrangement, discount, concession, or reimbursement structure
174.25 that has the effect of using medical assistance service revenue to offset the housing costs
174.26 of a person receiving services.

174.27 (c) Nothing in this subdivision prohibits a provider from charging a person for room
174.28 and board in accordance with chapter 504B or applicable housing support laws, provided
174.29 the charge is independent of medical assistance payments and complies with all federal
174.30 home and community-based services setting requirements, including but not limited to
174.31 tenancy protections under Code of Federal Regulations, title 42, section 441.301(c)(4)(vi)(A).

175.1 (d) The commissioner may pursue corrective action, payment recovery, sanctions under
175.2 section 256B.064, and licensing action under chapter 245A or 245D for a violation of this
175.3 subdivision.

175.4 (e) Notwithstanding paragraphs (a) and (b), payment for room and board is permitted
175.5 when explicitly included as part of a service authorized in a federally approved home and
175.6 community-based services waiver under United States Code, title 42, section 1396n(c).

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

175.8 Sec. 26. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 5a, is
175.9 amended to read:

175.10 Subd. 5a. **Base wage index; calculations.** The base wage index must be calculated as
175.11 follows:

175.12 (1) for supervisory staff, 100 percent of the median wage for community and social
175.13 services specialist (SOC code 21-1099), with the exception of the supervisor of positive
175.14 supports professional, positive supports analyst, and positive supports specialist, which is
175.15 100 percent of the median wage for clinical counseling and school psychologist (SOC code
175.16 19-3031);

175.17 (2) for registered nurse staff, 100 percent of the median wage for registered nurses (SOC
175.18 code 29-1141);

175.19 (3) for licensed practical nurse staff, 100 percent of the median wage for licensed practical
175.20 nurses (SOC code 29-2061);

175.21 (4) for residential asleep-overnight staff, the minimum wage in Minnesota for large
175.22 employers;

175.23 (5) for residential direct care staff, the sum of:

175.24 (i) 15 percent of the subtotal of 50 percent of the median wage for home health and
175.25 personal care aide (SOC code 31-1120); 30 percent of the median wage for nursing assistant
175.26 (SOC code 31-1131); and 20 percent of the median wage for social and human services
175.27 aide (SOC code 21-1093); and

175.28 (ii) 85 percent of the subtotal of 40 percent of the median wage for home health and
175.29 personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant
175.30 (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code
175.31 29-2053); and 20 percent of the median wage for social and human services aide (SOC code
175.32 21-1093);

176.1 (6) for adult day services staff, 70 percent of the median wage for nursing assistant (SOC
176.2 code 31-1131); and 30 percent of the median wage for home health and personal care aide
176.3 (SOC code 31-1120);

176.4 (7) for day support services staff and prevocational services staff, 20 percent of the
176.5 median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for
176.6 psychiatric technician (SOC code 29-2053); and 60 percent of the median wage for social
176.7 and human services aide (SOC code 21-1093);

176.8 (8) for positive supports analyst staff, 100 percent of the median wage for substance
176.9 abuse, behavioral disorder, and mental health counselor (SOC code 21-1018);

176.10 (9) for positive supports professional staff, 100 percent of the median wage for clinical
176.11 counseling and school psychologist (SOC code 19-3031);

176.12 (10) for positive supports specialist staff, 100 percent of the median wage for psychiatric
176.13 technicians (SOC code 29-2053);

176.14 (11) for individualized home supports with family training staff, 20 percent of the median
176.15 wage for nursing aide (SOC code 31-1131); 30 percent of the median wage for community
176.16 social service specialist (SOC code 21-1099); 40 percent of the median wage for social and
176.17 human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric
176.18 technician (SOC code 29-2053);

176.19 (12) for individualized home supports with training services staff, 40 percent of the
176.20 median wage for community social service specialist (SOC code 21-1099); 50 percent of
176.21 the median wage for social and human services aide (SOC code 21-1093); and ten percent
176.22 of the median wage for psychiatric technician (SOC code 29-2053);

176.23 (13) for employment support services staff, 50 percent of the median wage for
176.24 rehabilitation counselor (SOC code 21-1015); and 50 percent of the median wage for
176.25 community and social services specialist (SOC code 21-1099);

176.26 (14) for employment exploration services staff, 50 percent of the median wage for
176.27 education, guidance, school, and vocational counselor (SOC code 21-1012); and 50 percent
176.28 of the median wage for community and social services specialist (SOC code 21-1099);

176.29 (15) for employment development services staff, 50 percent of the median wage for
176.30 education, guidance, school, and vocational counselors (SOC code 21-1012); and 50 percent
176.31 of the median wage for community and social services specialist (SOC code 21-1099);

(16) for individualized home support without training staff, 50 percent of the median wage for home health and personal care aide (SOC code 31-1120); and 50 percent of the median wage for nursing assistant (SOC code 31-1131);

(17) effective until the effective date of clauses (18) and (19), for night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 percent of the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aide (SOC code 21-1093);

(18) effective January 1, 2026, or upon federal approval, whichever is later, for awake night supervision staff, 40 percent of the median wage for home health and personal care aide (SOC code 31-1120); 20 percent of the median wage for nursing assistant (SOC code 31-1131); 20 of percent the median wage for psychiatric technician (SOC code 29-2053); and 20 percent of the median wage for social and human services aid (SOC code 21-1093); ~~and~~

(19) effective January 1, 2026, or upon federal approval, whichever is later, for asleep night supervision staff, the minimum wage in Minnesota for large employers~~.~~; and

(20) for integrated community support staff, 40 percent of the median wage for community social service specialist (SOC code 21-1099); 50 percent of the median wage for social and human services aide (SOC code 21-1093); and ten percent of the median wage for psychiatric technician (SOC code 29-2053).

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

Sec. 27. Minnesota Statutes 2024, section 256B.4914, subdivision 6, is amended to read:

Subd. 6. **Residential support services; generally.** (a) For purposes of this section, residential support services includes 24-hour customized living services, community residential services, and customized living services~~, and integrated community supports~~.

(b) A unit of service for residential support services is a day. Any portion of any calendar day, within allowable Medicaid rules, where an individual spends time in a residential setting is billable as a day. The number of days authorized for all individuals enrolling in residential support services must include every day that services start and end.

(c) When the available shared staffing hours in a residential setting are insufficient to meet the needs of an individual who enrolled in residential support services after January 1, 2014, then individual staffing hours shall be used.

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

178.2 Sec. 28. Minnesota Statutes 2024, section 256B.4914, subdivision 6a, is amended to read:

178.3 Subd. 6a. **Community residential services; component values and calculation of**
178.4 **payment rates.** (a) Component values for community residential services are:

178.5 (1) competitive workforce factor: 6.7 percent;

178.6 (2) supervisory span of control ratio: 11 percent;

178.7 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

178.8 (4) employee-related cost ratio: 23.6 percent;

178.9 (5) general administrative support ratio: 13.25 percent;

178.10 (6) program-related expense ratio: 1.3 percent; and

178.11 (7) absence and utilization factor ratio: 3.9 percent.

178.12 (b) Payments for community residential services must be calculated as follows:

178.13 (1) determine the number of shared direct staffing and individual direct staffing hours
178.14 to meet a recipient's needs provided on site ~~or through monitoring technology~~;

178.15 (2) determine the appropriate hourly staff wage rates derived by the commissioner as
178.16 provided in subdivisions 5 and 5a;

178.17 (3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the
178.18 product of one plus the competitive workforce factor;

178.19 (4) for a recipient requiring customization for deaf and hard-of-hearing language
178.20 accessibility under subdivision 12, add the customization rate provided in subdivision 12
178.21 to the result of clause (3);

178.22 (5) multiply the number of shared direct staffing and individual direct staffing hours
178.23 provided on site ~~or through monitoring technology~~ and nursing hours by the appropriate
178.24 staff wages;

178.25 (6) multiply the number of shared direct staffing and individual direct staffing hours
178.26 provided on site ~~or through monitoring technology~~ and nursing hours by the product of the
178.27 supervision span of control ratio and the appropriate supervisory staff wage in subdivision
178.28 5a, clause (1);

178.29 (7) combine the results of clauses (5) and (6)~~, excluding any shared direct staffing and~~
178.30 ~~individual direct staffing hours provided through monitoring technology,~~ and multiply the

result by one plus the employee vacation, sick, and training allowance ratio. This is defined as the direct staffing cost;

(8) for employee-related expenses, multiply the direct staffing cost~~, excluding any shared direct staffing and individual hours provided through monitoring technology,~~ by one plus the employee-related cost ratio;

(9) for client programming and supports, add $2,260.21 divided by 365. The commissioner shall update the amount in this clause as specified in subdivision 5b;

(10) for transportation, if provided, add $1,742.62 divided by 365, or $3,111.81 divided by 365 if customized for adapted transport, based on the resident with the highest assessed need. The commissioner shall update the amounts in this clause as specified in subdivision 5b;

(11) subtotal clauses (8) to (10) ~~and the direct staffing cost of any shared direct staffing and individual direct staffing hours provided through monitoring technology that was excluded in clause (8)~~;

(12) sum the standard general administrative support ratio, the program-related expense ratio, and the absence and utilization factor ratio;

(13) divide the result of clause (11) by one minus the result of clause (12). This is the total payment amount; and

(14) adjust the result of clause (13) by a factor to be determined by the commissioner to adjust for regional differences in the cost of providing services.

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

Sec. 29. Minnesota Statutes 2024, section 256B.4914, subdivision 6b, is amended to read:

Subd. 6b. **Family residential services; component values and calculation of payment rates.** (a) Component values for family residential services are:

(1) competitive workforce factor: 6.7 percent;

(2) supervisory span of control ratio: 11 percent;

(3) employee vacation, sick, and training allowance ratio: 8.71 percent;

(4) employee-related cost ratio: 23.6 percent;

(5) general administrative support ratio: 3.3 percent;

180.1 (6) program-related expense ratio: 1.3 percent; and

180.2 (7) absence factor: 1.7 percent.

180.3 (b) Payments for family residential services must be calculated as follows:

180.4 (1) determine the number of shared direct staffing and individual direct staffing hours
180.5 to meet a recipient's needs provided on site ~~or through monitoring technology~~;

180.6 (2) determine the appropriate hourly staff wage rates derived by the commissioner as
180.7 provided in subdivisions 5 and 5a;

180.8 (3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the
180.9 product of one plus the competitive workforce factor;

180.10 (4) for a recipient requiring customization for deaf and hard-of-hearing language
180.11 accessibility under subdivision 12, add the customization rate provided in subdivision 12
180.12 to the result of clause (3);

180.13 (5) multiply the number of shared direct staffing and individual direct staffing hours
180.14 provided on site ~~or through monitoring technology~~ and nursing hours by the appropriate
180.15 staff wages;

180.16 (6) multiply the number of shared direct staffing and individual direct staffing hours
180.17 provided on site ~~or through monitoring technology~~ and nursing hours by the product of the
180.18 supervisory span of control ratio and the appropriate supervisory staff wage in subdivision
180.19 5a, clause (1);

180.20 (7) combine the results of clauses (5) and (6)~~, excluding any shared direct staffing and~~
180.21 ~~individual direct staffing hours provided through monitoring technology,~~ and multiply the
180.22 result by one plus the employee vacation, sick, and training allowance ratio. This is defined
180.23 as the direct staffing cost;

180.24 (8) for employee-related expenses, multiply the direct staffing cost~~, excluding any shared~~
180.25 ~~and individual direct staffing hours provided through monitoring technology,~~ by one plus
180.26 the employee-related cost ratio;

180.27 (9) for client programming and supports, add $2,260.21 divided by 365. The
180.28 commissioner shall update the amount in this clause as specified in subdivision 5b;

180.29 (10) for transportation, if provided, add $1,742.62 divided by 365, or $3,111.81 divided
180.30 by 365 if customized for adapted transport, based on the resident with the highest assessed
180.31 need. The commissioner shall update the amounts in this clause as specified in subdivision
180.32 5b;

181.1 (11) subtotal clauses (8) to (10) ~~and the direct staffing cost of any shared direct staffing~~
181.2 ~~and individual direct staffing hours provided through monitoring technology that was~~
181.3 ~~excluded in clause (8)~~;

181.4 (12) sum the standard general administrative support ratio, the program-related expense
181.5 ratio, and the absence and utilization factor ratio;

181.6 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
181.7 total payment rate; and

181.8 (14) adjust the result of clause (13) by a factor to be determined by the commissioner
181.9 to adjust for regional differences in the cost of providing services.

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

181.12 Sec. 30. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision
181.13 to read:

181.14 Subd. 8a. **Integrated community supports unit-based services with programming;**
181.15 **component values and calculation of payment rates.** (a) Component values for integrated
181.16 community supports unit-based services with programming are:

181.17 (1) competitive workforce factor: 6.7 percent;

181.18 (2) supervisory span of control ratio: 11 percent;

181.19 (3) employee vacation, sick, and training allowance ratio: 8.71 percent;

181.20 (4) employee-related cost ratio: 23.6 percent;

181.21 (5) program plan support ratio: 27 percent;

181.22 (6) client programming and support ratio: 9.2 percent;

181.23 (7) general administrative support ratio: 13.25 percent;

181.24 (8) program-related expense ratio: 6.1 percent; and

181.25 (9) absence and utilization factor ratio: 9.4 percent.

181.26 (b) A unit of integrated community supports unit-based services with programming is
181.27 15 minutes.

181.28 (c) Payments for integrated community supports must be calculated as follows:

181.29 (1) determine the number of units of service to meet a recipient's needs;

182.1 (2) determine the appropriate hourly staff wage rates derived by the commissioner as
182.2 provided in subdivisions 5 and 5a;

182.3 (3) except for subdivision 5a, clauses (1) to (4), multiply the result of clause (2) by the
182.4 product of one plus the competitive workforce factor;

182.5 (4) for a recipient requiring customization for deaf and hard-of-hearing language
182.6 accessibility under subdivision 12, add the customization rate provided in subdivision 12
182.7 to the result of clause (3);

182.8 (5) multiply the number of direct staffing hours by the appropriate staff wage;

182.9 (6) multiply the number of direct staffing hours by the product of the supervisory span
182.10 of control ratio and the appropriate supervisory staff wage in subdivision 5a, clause (1);

182.11 (7) combine the results of clauses (5) and (6), and multiply the result by one plus the
182.12 employee vacation, sick, and training allowance ratio. This is defined as the direct staffing
182.13 rate;

182.14 (8) for program plan support, multiply the result of clause (7) by one plus the program
182.15 plan support ratio divided by the approved capacity for the integrated community supports
182.16 setting;

182.17 (9) for employee-related expenses, multiply the result of clause (8) by one plus the
182.18 employee-related cost ratio;

182.19 (10) for client programming and supports, multiply the result of clause (9) by one plus
182.20 the client programming and support ratio;

182.21 (11) this is the subtotal rate;

182.22 (12) sum the standard general administrative support ratio, the program-related expense
182.23 ratio, and the absence and utilization factor ratio; and

182.24 (13) divide the result of clause (11) by one minus the result of clause (12). This is the
182.25 total payment amount.

182.26 (d) The commissioner must establish maximum allowable in-person and remote service
182.27 hours used in the rate methodology for integrated community supports based on the recipient's
182.28 case-mix classification. The total number of service hours entered into the rate framework
182.29 must not exceed the following limits:

182.30 (1) for case mix classifications A, C, and L, a maximum of two hours per day;

182.31 (2) for case mix classifications B, D, and F, a maximum of four hours per day;

183.1 (3) for case mix classifications E, G, I, J, and K, a maximum of six hours per day; and

183.2 (4) for case mix classification H, a maximum of eight hours per day.

183.3 (e) The daily limit in paragraph (d) does not limit a person's use of other disability waiver
183.4 services, which may be provided on the same day by the same provider providing integrated
183.5 community supports. Nothing in paragraph (d) prohibits approval of a rate exception for
183.6 individuals with exceptional or complex needs.

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

183.8 Sec. 31. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision
183.9 to read:

183.10 Subd. 10e. **Documentation of staffing; auditing and rate review.** (a) Effective for
183.11 services provided on or after January 1, 2029, a provider enrolled to provide residential
183.12 services under subdivision 6 must maintain documentation of direct staffing hours provided
183.13 to each person receiving services, including but not limited to documentation identifying:

183.14 (1) the name, role, and unique identifier for each staff person who provided services to
183.15 match records to payroll, time and attendance systems, and any other source documentation;

183.16 (2) the date services were provided;

183.17 (3) the total number of hours of direct support provided;

183.18 (4) awake overnight staffing hours provided, if applicable;

183.19 (5) asleep overnight staffing hours provided, if applicable; and

183.20 (6) any other staffing information required by the commissioner.

183.21 (b) A provider must maintain documentation in a manner and format determined by the
183.22 commissioner for at least six years. If a provider changes payroll vendors, merges operations,
183.23 or changes staffing identifiers, the provider must maintain a documented link between prior
183.24 and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and
183.25 role classification for each staff person.

183.26 (c) A provider must submit the documentation required under paragraph (a) to the
183.27 commissioner annually, in a manner and format determined by the commissioner. The
183.28 commissioner must establish multiple submission windows throughout the calendar year
183.29 and may assign providers to a submission window for administrative efficiency and system
183.30 capacity. Documentation must reflect staffing provided during the prior calendar year and
183.31 must be submitted no later than the final business day of the provider's assigned submission

184.1 window. The commissioner may conduct random or targeted validations and audits of
184.2 submitted data and may require supplemental documentation as necessary to verify accuracy
184.3 and compliance.

184.4 (d) The commissioner must conduct periodic analysis of documentation submitted under
184.5 this subdivision and may validate staffing data through random audits or other verification
184.6 methods.

184.7 (e) Based on the analysis under paragraph (d), the commissioner may provide
184.8 recommendations to lead agencies regarding modifications to the rate of a person receiving
184.9 services, including increases or decreases necessary to align the rate with staffing provided
184.10 to the person as demonstrated by the submitted historical staffing documentation.
184.11 Recommendations must be based on the requirements of this section and applicable federal
184.12 and state requirements governing rate setting.

184.13 (f) If a provider fails to submit documentation requested within the submission window
184.14 in paragraph (c), the commissioner must issue a written notice of noncompliance. If
184.15 documentation is not received within 60 days following the notice of noncompliance, the
184.16 commissioner may temporarily suspend payments to the provider until the required
184.17 documentation is submitted. The commissioner must make withheld payments to the provider
184.18 once the required documentation is received. If such noncompliance persists, the
184.19 commissioner may adjust future rate payments, require the provider to submit a corrective
184.20 action plan, or pursue other enforcement actions as authorized by law.

184.21 (g) The commissioner must publish annual aggregate reports summarizing audit findings
184.22 and trends related to staffing provided under this section.

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

184.24 Sec. 32. Minnesota Statutes 2024, section 256B.4914, is amended by adding a subdivision
184.25 to read:

184.26 Subd. 21. **Administrative fees charged by providers and vendors.** Effective July 1,
184.27 2027, or upon federal approval, whichever is later, the commissioner must limit
184.28 administrative fees charged by enrolled providers and vendors approved by lead agencies
184.29 to no more than six percent of the total cost of the service or purchased goods. This limit
184.30 applies to the following services and other new market rate services as determined by the
184.31 commissioner:

184.32 (1) chore services billed daily;

184.33 (2) transitional services; and

185.1 (3) transportation.

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

185.3 Sec. 33. Minnesota Statutes 2024, section 256B.492, is amended by adding a subdivision
185.4 to read:

185.5 Subd. 4. **Integrated community supports setting approval moratorium and**
185.6 **exception.** (a) The commissioner must not approve a new integrated community supports
185.7 setting or approve an expansion of an existing integrated community supports setting except
185.8 as provided in this subdivision.

185.9 (b) The commissioner may approve an exception to the moratorium only when the
185.10 applicant demonstrates indirect control of the setting and compliance with:

185.11 (1) the federal home and community-based services requirements under Code of Federal
185.12 Regulations, title 42, section 441.301(c);

185.13 (2) the prohibition on the use of medical assistance money for room and board under
185.14 section 256B.4912, subdivision 17;

185.15 (3) independent lease requirements consistent with chapter 504B; and

185.16 (4) all documentation requirements under section 245D.12.

185.17 (c) To approve an exception, the commissioner must determine that the lead agency has
185.18 requested the additional capacity to meet the specific disability-related needs of the person.
185.19 Priority must be given to geographic regions with insufficient integrated community supports
185.20 capacity based on statewide or regional needs determination processes.

185.21 (d) For purposes of this subdivision, "integrated community supports setting" means a
185.22 multifamily housing building where a provider delivers integrated community supports
185.23 under section 245D.03, subdivision 1, paragraph (c), clause (8), and for which a provider
185.24 has a provider-controlled or provider-associated financial interest as defined under section
185.25 245A.02, subdivision 10b.

185.26 (e) A determination under this subdivision is final and not subject to appeal.

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

185.28 Sec. 34. Minnesota Statutes 2024, section 256I.03, subdivision 10a, is amended to read:

185.29 Subd. 10a. **Housing support.** "Housing support" means assistance that provides at a
185.30 minimum room and board to persons who meet the eligibility requirements of section

256I.04. To receive payment for housing support, the residence must meet the requirements under:

(1) section 256I.04, ~~subdivisions~~ subdivision 2a or 256I.041; and

(2) section 256I.04, subdivisions 2b to 2f.

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

Sec. 35. Minnesota Statutes 2024, section 256I.04, subdivision 1, is amended to read:

Subdivision 1. **Individual eligibility requirements.** An individual is eligible for and entitled to a housing support payment to be made on the individual's behalf if ~~the~~ an agency ~~has approved the setting~~ or the commissioner has a housing support agreement with the establishment where the individual will receive housing support and the individual meets the requirements in paragraph (a), (b), (c), or (d).

(a) The individual is aged, blind, or is over 18 years of age with a disability as determined under the criteria used by the title II program of the Social Security Act, and meets the resource restrictions and standards of section 256P.02, and the individual's countable income after deducting the (1) exclusions and disregards of the SSI program, (2) the medical assistance personal needs allowance under section 256B.35, and (3) an amount equal to the income actually made available to a community spouse by an elderly waiver participant under the provisions of sections 256B.0575, paragraph (a), clause (4), and 256B.058, subdivision 2, is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(b) The individual meets a category of eligibility under section 256D.05, subdivision 1, paragraph (a), clauses (1), (3), (4) to (8), and (13), and paragraph (b), if applicable, and the individual's resources are less than the standards specified by section 256P.02, and the individual's countable income as determined under section 256P.06, less the medical assistance personal needs allowance under section 256B.35 is less than the monthly rate specified in the agency's agreement with the provider of housing support in which the individual resides.

(c) The individual lacks a fixed, adequate, nighttime residence upon discharge from a residential behavioral health treatment program, as determined by treatment staff from the residential behavioral health treatment program. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following discharge from treatment, plus two full months.

(d) The individual meets the criteria related to establishing a certified disability or disabling condition in paragraph (a) or (b) and lacks a fixed, adequate, nighttime residence upon discharge from a correctional facility, as determined by an authorized representative from a Minnesota-based correctional facility. An individual is eligible under this paragraph for up to three months, including a full or partial month from the individual's move-in date at a setting approved for housing support following release, plus two full months. Any income received by people who meet the disabling condition criteria established in paragraph (a) or (b) is not countable for the duration of eligibility under this paragraph.

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

Sec. 36. Minnesota Statutes 2025 Supplement, section 256I.04, subdivision 2a, is amended to read:

Subd. 2a. **License required; staffing qualifications.** (a) Except as provided in paragraph (b), an agency may not enter into an agreement with an establishment to provide housing support unless:

(1) the establishment is licensed by the Department of Health as a hotel and restaurant; a board and lodging establishment; a boarding care home before March 1, 1985; or a supervised living facility, and the service provider for residents of the facility is licensed under chapter 245A. However, an establishment licensed by the Department of Health to provide lodging need not also be licensed to provide board if meals are being supplied to residents under a contract with a food vendor who is licensed by the Department of Health; or

(2) the residence is: (i) licensed by the commissioner of human services under Minnesota Rules, parts 9555.5050 to 9555.6265; (ii) certified by a county human services agency prior to July 1, 1992, using the standards under Minnesota Rules, parts 9555.5050 to 9555.6265; (iii) licensed by the commissioner under Minnesota Rules, parts 2960.0010 to 2960.0120, with a variance under section 245A.04, subdivision 9; or (iv) licensed under section 245D.02, subdivision 4a, as a community residential setting by the commissioner of human services; or

(3) the facility is licensed under chapter 144G and provides three meals a day~~; or~~.

~~(4) effective January 1, 2027, the establishment is licensed by the Department of Health as a board and lodging establishment and is certified by the commissioner as a recovery residence in accordance with section 254B.215, subdivision 3, that is subject to the~~

188.1 ~~requirements of section 256I.04, subdivisions 2a to 2f. The Department of Human Services~~
188.2 ~~must serve as the lead agency for agreements entered into under this clause.~~

188.3 (b) ~~The requirements under paragraph (a) do not apply to establishments~~ An agency
188.4 may enter into an agreement to provide housing support with an establishment exempt from
188.5 state licensure because ~~they are~~ it is:

188.6 (1) located on an Indian ~~reservations~~ reservation and subject to tribal health and safety
188.7 requirements; or

188.8 (2) a supportive housing ~~establishments~~ establishment where an individual has an
188.9 approved habitability inspection and an individual lease agreement.

188.10 (c) Supportive housing establishments that serve individuals who have experienced
188.11 long-term homelessness and emergency shelters must participate in the homeless management
188.12 information system and a coordinated assessment system as defined by the commissioner.

188.13 (d) ~~Effective July 1, 2016,~~ An agency shall not have an agreement with a provider of
188.14 housing support unless all staff members who have direct contact with recipients:

188.15 (1) have skills and knowledge acquired through one or more of the following:

188.16 (i) a course of study in a health- or human services-related field leading to a bachelor
188.17 of arts, bachelor of science, or associate's degree;

188.18 (ii) one year of experience with the target population served;

188.19 (iii) experience as a mental health certified peer specialist according to section 256B.0615;
188.20 or

188.21 (iv) meeting the requirements for unlicensed personnel under sections 144A.43 to
188.22 144A.483;

188.23 (2) hold a current driver's license appropriate to the vehicle driven if transporting
188.24 recipients;

188.25 (3) complete training on vulnerable adults mandated reporting and child maltreatment
188.26 mandated reporting, where applicable; and

188.27 (4) complete housing support orientation training offered by the commissioner.

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

189.1 Sec. 37. Minnesota Statutes 2024, section 256I.04, subdivision 2f, is amended to read:

189.2 Subd. 2f. **Required services.** (a) In ~~authorized~~ settings authorized under subdivision 2a
189.3 or under section 256I.041, providers ~~shall~~ must ensure that participants have at a minimum:

189.4 (1) food preparation and service for three nutritional meals a day on site;

189.5 (2) a bed, clothing storage, linen, bedding, laundering, and laundry supplies or service;

189.6 (3) housekeeping, including cleaning and lavatory supplies or service; and

189.7 (4) maintenance and operation of the building and grounds, including heat, water, garbage
189.8 removal, electricity, telephone for the site, cooling, supplies, and parts and tools to repair
189.9 and maintain equipment and facilities.

189.10 (b) In addition, when providers serve participants described in subdivision 1, paragraph
189.11 (c), the providers are required to assist the participants in applying for continuing housing
189.12 support payments before the end of the eligibility period.

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

189.14 Sec. 38. **[256I.041] STATE-EXECUTED HOUSING SUPPORT AGREEMENTS.**

189.15 Subdivision 1. **State-executed housing support agreements.** At the request of the
189.16 establishment, the commissioner may enter into a housing support agreement with the
189.17 following types of establishments:

189.18 (1) a residence with an approved integrated community supports setting capacity report
189.19 submitted under section 245D.12; and

189.20 (2) an establishment licensed by the commissioner of health as a board and lodging
189.21 establishment and designated by the commissioner of human services as a level-two certified
189.22 recovery residence under section 254B.215, subdivision 3.

189.23 Subd. 2. **Requirements of state-executed housing support agreements.** All housing
189.24 support agreements into which the commissioner enters under this section are subject to the
189.25 same requirements and limitations as housing support agreements entered into by other
189.26 agencies, including the requirements of section 256I.04, subdivisions 2a to 2f.

189.27 Subd. 3. **Prohibited agreements.** The commissioner must not enter into housing support
189.28 agreements with any establishment not described in subdivision 1.

189.29 Subd. 4. **Administration of state-executed housing support agreements.** For each
189.30 state-executed housing support agreement, the commissioner must designate an agency that

190.1 must administer the agreement, including determining eligibility for housing support and
190.2 making payments in accordance with the terms of the agreement.

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

190.4 Sec. 39. Minnesota Statutes 2024, section 256I.05, subdivision 11, is amended to read:

190.5 Subd. 11. **Cost-neutral transfers from the housing support fund.** (a) The commissioner
190.6 is authorized to make cost-neutral transfers from the housing support fund for beds under
190.7 this section to other funding programs administered by the department after consultation
190.8 with the agency in which the affected beds are located.

190.9 (b) The commissioner may also make cost-neutral transfers from the housing support
190.10 fund to agencies for beds removed from the housing support census under a plan submitted
190.11 by the agency and approved by the commissioner.

190.12 (c) The commissioner shall make a cost-neutral transfer of funding from the housing
190.13 support fund to the agency for emergency shelter beds removed from the housing support
190.14 census under a plan submitted by the agency and approved by the commissioner. Plans
190.15 submitted under this paragraph must include anticipated and actual outcomes for persons
190.16 experiencing homelessness in emergency shelters.

190.17 (d) Plans submitted under paragraph (b) or (c) must describe: (1) improved efficiencies
190.18 in administration; (2) requirements for individual eligibility; and (3) plans for quality
190.19 assurance monitoring and quality assurance outcomes. The commissioner shall review
190.20 agency plans to monitor implementation and outcomes at least biennially, and more
190.21 frequently if the commissioner deems necessary.

190.22 (e) Funding under paragraph (b), (c), or (d) may be used for the provision of room and
190.23 board or supplemental services according to section 256I.03, subdivisions 14a and 14b.
190.24 Providers must meet the requirements of both (1) either section 256I.04, subdivision 2a, or
190.25 section 256I.041, and (2) section 256I.04, subdivisions ~~2a~~ 2b to 2f. Funding must be allocated
190.26 annually, and the room and board portion of the allocation shall be adjusted according to
190.27 the percentage change in the housing support room and board rate. The commissioner or
190.28 agency may return beds to the housing support fund with 180 days' notice, including financial
190.29 reconciliation.

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

191.1 Sec. 40. Minnesota Statutes 2024, section 256R.10, subdivision 8, is amended to read:

191.2 Subd. 8. **Employer health insurance costs.** (a) Employer health insurance costs are
191.3 allowable for (1) all nursing facility employees and (2) the spouse and dependents of those
191.4 nursing facility employees who are employed on average at least 30 hours per week.

191.5 (b) The commissioner must not treat employer contributions to employer-sponsored
191.6 individual coverage health reimbursement arrangements as allowable costs if the facility
191.7 does not provide the commissioner copies of the employer-sponsored individual coverage
191.8 health reimbursement arrangement plan documents and documentation of any health
191.9 insurance premiums and associated co-payments reimbursed under the arrangement.
191.10 Documentation of reimbursements must denote any reimbursements for health insurance
191.11 premiums or associated co-payments incurred by the spouses or dependents of nursing
191.12 facility employees who work on average less than 30 hours per week.

191.13 (c) Effective for the rate year beginning January 1, 2027, the annual reimbursement cap
191.14 for health insurance costs is $15,000 as adjusted according to paragraph (d). The allowable
191.15 costs for health insurance must not exceed the reimbursement cap multiplied by the annual
191.16 average month-end number of allowed enrolled nursing facility employees from the
191.17 applicable cost report period. For shared employees, the allowable number of enrolled
191.18 employees includes only the nursing facility percentage of any shared allowed enrolled
191.19 employees. The allowable number of enrolled employees must not include nonnursing
191.20 facility employees or individuals who elect COBRA continuation coverage.

191.21 (d) Effective for rate years beginning on or after January 1, 2028, the commissioner
191.22 shall adjust the annual reimbursement cap for employer health insurance costs by the previous
191.23 year's cap plus an adjustment for CPI-U inflation as defined in section 256R.02, subdivision
191.24 14a.

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

191.26 Sec. 41. Minnesota Statutes 2024, section 256R.23, subdivision 5, is amended to read:

191.27 Subd. 5. **Determination of total care-related payment rate limits.** (a) Effective until
191.28 December 31, 2027, the commissioner must determine each facility's total care-related
191.29 payment rate limit by:

191.30 (1) multiplying the facility's quality score, as determined under section 256R.16,
191.31 subdivision 1, by 0.5625;

191.32 (2) adding 89.375 to the amount determined in clause (1), and dividing the total by 100;
191.33 and

192.1 (3) multiplying the amount determined in clause (2) by the median total care-related
192.2 cost per day.

192.3 (b) Effective January 1, 2028, the commissioner must determine each facility's total
192.4 care-related payment rate limit by:

192.5 (1) multiplying the facility's quality score, as determined under section 256R.16,
192.6 subdivision 1, by two;

192.7 (2) subtracting 40 from the amount determined in clause (1), and dividing the total by
192.8 100; and

192.9 (3) multiplying the amount determined in clause (2) by the median total care-related
192.10 cost per day.

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

192.12 Sec. 42. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision
192.13 to read:

192.14 Subd. 4. **Documentation of staffing; auditing and rate review for residential support**
192.15 **services.** (a) For purposes of this subdivision, residential support services include 24-hour
192.16 customized living services, customized living services, family adult foster care, and corporate
192.17 adult foster care.

192.18 (b) Effective January 1, 2029, a provider enrolled to provide residential services under
192.19 this subdivision must maintain documentation of direct staffing hours provided to each
192.20 person receiving services, including but not limited to documentation identifying:

192.21 (1) the name, role, and unique identifier for each staff person who provided services to
192.22 match records to payroll, time and attendance systems, and any other source documentation;

192.23 (2) the date services were provided;

192.24 (3) the total number of hours of direct support provided;

192.25 (4) awake overnight staffing hours provided, if applicable;

192.26 (5) asleep overnight staffing hours provided, if applicable; and

192.27 (6) any other staffing information required by the commissioner.

192.28 (c) A provider must maintain documentation in a manner and format determined by the
192.29 commissioner for at least six years. If a provider changes payroll vendors, merges operations,
192.30 or changes staffing identifiers, the provider must maintain a documented link between prior

193.1 and current staffing identifiers sufficient to allow tracking of hours worked, turnover, and
193.2 role classification for each staff person.

193.3 (d) A provider must submit the documentation required under paragraph (b) to the
193.4 commissioner annually, in a manner and format determined by the commissioner. The
193.5 commissioner must establish multiple submission windows throughout the calendar year
193.6 and may assign providers to a submission window for administrative efficiency and system
193.7 capacity. Documentation must reflect staffing provided during the prior calendar year and
193.8 must be submitted no later than the final business day of the provider's assigned submission
193.9 window. The commissioner may conduct random or targeted validations and audits of
193.10 submitted data and may require supplemental documentation as necessary to verify accuracy
193.11 and compliance.

193.12 (e) The commissioner must conduct periodic analysis of documentation submitted under
193.13 this subdivision and may validate staffing data through random audits or other verification
193.14 methods.

193.15 (f) Based on the analysis under paragraph (e), the commissioner may provide
193.16 recommendations to lead agencies regarding modifications to the rate of the person receiving
193.17 services, including increases or decreases necessary to align the rate with staffing provided
193.18 to the person as demonstrated by the submitted historical staffing documentation.
193.19 Recommendations must be based on the requirements of this section and applicable federal
193.20 and state requirements governing rate setting.

193.21 (g) If a provider fails to submit documentation requested within the submission window
193.22 under paragraph (c), the commissioner must issue a written notice of noncompliance. If
193.23 documentation is not received within 60 days following the notice of noncompliance, the
193.24 commissioner may temporarily suspend payments to the provider until the required
193.25 documentation is submitted. The commissioner must make withheld payments to the provider
193.26 once the required documentation is received. If such noncompliance persists, the
193.27 commissioner may adjust future rate payments, require the provider to submit a corrective
193.28 action plan, or pursue other enforcement actions as authorized by law.

193.29 (h) The commissioner must publish annual aggregate reports summarizing audit findings
193.30 and trends related to staffing provided under this section.

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

194.1 Sec. 43. Minnesota Statutes 2024, section 256S.21, is amended by adding a subdivision
194.2 to read:

194.3 Subd. 5. **Administrative fees charged by providers or vendors.** The commissioner
194.4 must limit administrative fees charged by enrolled providers or vendors approved by lead
194.5 agencies to no more than six percent of the total cost of the service or purchased goods.
194.6 This limit applies to the following services but allows for the addition of other services
194.7 determined by the commissioner:

194.8 (1) chore services billed daily;

194.9 (2) transitional services; and

194.10 (3) transportation.

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

194.12 Sec. 44. **WAIVER AMENDMENTS; REMOTE SUPPORTS.**

194.13 (a) The commissioner of human services must seek federal approval from the Centers
194.14 for Medicare and Medicaid Services to amend the state's home and community-based
194.15 services waiver plans under United States Code, title 42, section 1396n(c), to remove
194.16 authorization for the use of remote supports as a method of service delivery for the following
194.17 services:

194.18 (1) adult day services;

194.19 (2) community residential services;

194.20 (3) day support services;

194.21 (4) family residential services; and

194.22 (5) integrated community supports.

194.23 (b) An individual receiving remote supports as a method of service delivery in a service
194.24 plan approved prior to the date federal approval is received may continue to receive remote
194.25 supports as a method of service delivery until support planning is completed at annual
194.26 reassessment.

194.27 (c) Until federal approval is obtained, the commissioner must continue to allow the use
194.28 of remote support only to the extent permitted under the terms of the state's federally
194.29 approved waiver plans in effect on the effective date of this section.

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

195.1 Sec. 45. **MARKET RATE STUDY FOR HOME AND COMMUNITY-BASED**
195.2 **SERVICES.**

195.3 (a) The commissioner of human services must conduct a market rate study to evaluate
195.4 the adequacy, sustainability, and equity of payment rates for specific home and
195.5 community-based services under the home and community-based services waivers authorized
195.6 under Minnesota Statutes, sections 256B.092 and 256B.49.

195.7 (b) The study must include, at minimum, an analysis of the following services:

195.8 (1) employment support services delivered in remote or virtual settings;

195.9 (2) 24-hour emergency assistance;

195.10 (3) assistive technology;

195.11 (4) environmental accessibility adaptations;

195.12 (5) chore services;

195.13 (6) transitional services;

195.14 (7) independent living skills training; and

195.15 (8) specialist services, including positive support services and orientation and mobility
195.16 services.

195.17 (c) In planning and conducting the market rate study, the commissioner must consult
195.18 with interested parties, including but not limited to service providers, people with disabilities,
195.19 lead agencies, Tribal Nations, culturally specific and community-based providers, and
195.20 disability advocacy organizations. The consultation process must be designed to ensure
195.21 meaningful participation from providers in greater Minnesota and from providers serving
195.22 communities of color and Tribal Nations.

195.23 (d) In conducting the study, the commissioner must analyze provider costs, workforce
195.24 availability, wage competitiveness, regional market conditions, inflationary impacts, and
195.25 access issues. The commissioner must also evaluate whether current reimbursement
195.26 methodologies reflect actual costs of providing services and support long-term access to
195.27 qualified providers.

195.28 (e) By February 15, 2027, the commissioner must submit a report with findings and
195.29 recommendations, including but not limited to any proposed statutory changes, to the chairs
195.30 and ranking minority members of the legislative committees with jurisdiction over health
195.31 and human services policy and finance.

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

196.2 Sec. 46. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
196.3 **METHOD OF VISIT VERIFICATION.**

196.4 The commissioner must develop methods for collecting signatures required under
196.5 Minnesota Statutes, section 256B.073, subdivision 2, paragraph (c), clause (7), of the service
196.6 recipient, the service recipient's legal guardian or conservator, or the service recipient's
196.7 parent, if the service recipient is a minor, on a statement acknowledging that providing false
196.8 information on an electronic visit verification is a federal crime and attesting to the accuracy
196.9 of the information contained on an electronic visit verification. The methods may differ to
196.10 meet the needs of the service recipient, the service recipient's legal guardian or conservator,
196.11 or the service recipient's parent, if the service recipient is a minor.

196.12 Sec. 47. **REPEALER.**

196.13 (a) Minnesota Statutes 2024, section 256B.073, subdivision 4, is repealed.

196.14 (b) Minnesota Statutes 2024, sections 245A.70; 245A.71; 245A.72; 245A.73; 245A.74;
196.15 245A.75; and 245D.261, are repealed.

196.16 (c) Minnesota Statutes 2024, section 256B.4914, subdivision 6c, is repealed.

196.17 **EFFECTIVE DATE.** Paragraph (a) is effective July 1, 2026. Paragraphs (b) and (c)
196.18 are effective January 1, 2027, or upon federal approval, whichever is later.

196.19 **ARTICLE 6**
196.20 **HUMAN SERVICES ADMINISTRATIVE REFORM**

196.21 Section 1. Minnesota Statutes 2024, section 16A.103, is amended by adding a subdivision
196.22 to read:

196.23 Subd. 5. **Medical assistance; detailed costs.** (a) In the forecast of state revenues and
196.24 expenditures under subdivision 1, the commissioner must include forecasted costs of each
196.25 covered service provided under medical assistance.

196.26 (b) At the time of delivering the forecast of state revenues and expenditures under
196.27 subdivision 1, the commissioner, in consultation with the commissioner of human services,
196.28 must submit a report to the chairs and ranking minority members of the legislative committees
196.29 with jurisdiction over medical assistance that includes the information required under
196.30 paragraph (a) and identifies the covered services that are mandatory benefits under federal
196.31 law and regulations.

197.1 Sec. 2. Minnesota Statutes 2024, section 256B.05, subdivision 1, is amended to read:

197.2 Subdivision 1. **Administration of medical assistance.** (a) The county agencies shall
197.3 administer medical assistance in their respective counties under the supervision of the state
197.4 agency and the commissioner of human services as specified in section 256.01, and shall
197.5 make such reports, prepare such statistics, and keep such records and accounts in relation
197.6 to medical assistance as the state agency may require under section 256.01, subdivision 2,
197.7 paragraph (o).

197.8 (b) The commissioner may administer specific duties related to determining medical
197.9 assistance eligibility on behalf of county agency administrations to ensure compliance with
197.10 federal and state requirements for the medical assistance program. If the commissioner
197.11 elects to assume specific duties under this paragraph, the commissioner must undertake the
197.12 assumed duties on a statewide and uniform administrative and operational basis.

197.13 Sec. 3. **DIRECTION TO COMMISSIONER; TRANSFER ASSESSMENT.**

197.14 (a) The commissioner of human services must procure a contract with a vendor to assess
197.15 the current status of administration of medical assistance and plan for a transfer of
197.16 administration of medical assistance to the commissioner by January 1, 2033. The
197.17 commissioner must submit the assessment and plan to the chairs and ranking minority
197.18 members of the legislative committees with jurisdiction over human services and health
197.19 care policy and finance by October 1, 2028.

197.20 (b) The assessment and plan must include:

197.21 (1) a comprehensive assessment of medical assistance eligibility functions performed
197.22 by counties and Tribal governments, including identification of handoffs between county
197.23 and Tribal eligibility workers and state eligibility workers, and a catalog of eligibility
197.24 functions performed by state eligibility workers;

197.25 (2) examination of current expenditures, administrative budgets, and federal financial
197.26 participation in county and Tribal administrative work related to medical assistance eligibility
197.27 activities;

197.28 (3) eligibility system review, mapping, and recommended updates; and

197.29 (4) recommendations for a successful transition of centralized eligibility functions based
197.30 on consultation with stakeholders, review of information provided by county and Tribal
197.31 governments, review of other states' best practices for maximizing federal dollars, a feasible
197.32 timeline of activities, and required legislative changes and actions.

198.1 (c) The commissioner must consult with Minnesota's Tribal Nations, the Association of
198.2 Minnesota Counties, and the Minnesota Association of County Social Service Administrators
198.3 on the final deliverables included in the assessment.

198.4 Sec. 4. **DIRECTION TO COMMISSIONER; ASSESSMENT OF ADMINISTRATIVE**
198.5 **ROLES.**

198.6 (a) The commissioner of human services, in consultation with Minnesota's Tribal Nations
198.7 and counties, must conduct a study to assess and recommend improvements to the roles and
198.8 responsibilities of the state agency, counties, and Minnesota's Tribal Nations in administering
198.9 human services programs.

198.10 (b) The study must include a comprehensive review of programs administered by the
198.11 department, including but not limited to medical assistance, MinnesotaCare, behavioral
198.12 health services, long-term services and supports, housing and homelessness programs,
198.13 Minnesota supplemental aid, general assistance, and licensing and oversight functions.

198.14 (c) The study must evaluate the:

198.15 (1) current roles and responsibilities held by the state agency, counties, and Minnesota's
198.16 Tribal Nations in administering human services programs, including but not limited to the
198.17 challenges and benefits of the current delegation of roles and responsibilities;

198.18 (2) lived experience of people accessing human services programs related to the
198.19 delegation of administrative duties;

198.20 (3) financing of human services program administration across the state agency, counties,
198.21 and Minnesota's Tribal Nations; and

198.22 (4) administration of human services programs in other states, focusing on the roles and
198.23 responsibilities of the local governments versus the state Medicaid or human services agency,
198.24 and identifying the benefits, challenges, and financing of the delegation of duties.

198.25 (d) The study must focus on the goals of transforming the human services system to
198.26 ensure a transparent, accessible, accountable, equitable, and effective human services system.

198.27 (e) The study must provide recommendations for the optimal delegation of duties between
198.28 the state agency, counties, and Minnesota's Tribal Nations in the delivery of human services.
198.29 Recommendations must include:

198.30 (1) how the delegation of duties will improve the experience of people accessing human
198.31 services;

198.32 (2) implementation and timing considerations to ensure continuity of services;

199.1 (3) systems technology adaptations required;

199.2 (4) workforce considerations; and

199.3 (5) financing strategies and the estimated fiscal impact to the state budget.

199.4 (f) By October 1, 2028, the commissioner must submit a report on the study and
199.5 recommendations to the chairs and ranking minority members of the legislative committees
199.6 with jurisdiction over health and human services policy and finance.

199.7 Sec. 5. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES;**
199.8 **EVALUATION OF DHS STRUCTURE AND PROCESSES.**

199.9 (a) The commissioner of human services must contract with an external consultant to
199.10 continue and complete the project initiated under Executive Order 25-10, section 1, paragraph
199.11 (g), to make recommendations to improve the Department of Human Services' performance
199.12 as the state's Medicaid agency. The external consultant must evaluate the department's
199.13 structure and processes and assess the adequacy of the department's current policies,
199.14 procedures, systems, organizational structure, staffing levels, and funding to effectively
199.15 increase program integrity, minimize fraud, and more effectively serve as the state's Medicaid
199.16 agency.

199.17 (b) By October 1, 2026, the commissioner must submit a report to the chairs and ranking
199.18 minority members of the legislative committees with jurisdiction over health and human
199.19 services policy and finance. The report must include information on the recommendations
199.20 of the external contractor made through September 30, 2026, and any actions the
199.21 commissioner has taken in response to the external contractor's recommendations or other
199.22 actions taken by the commissioner pursuant to Executive Order 25-10, section 1, paragraph
199.23 (g), through September 30, 2026.

199.24 (c) By October 1, 2027, the commissioner must submit a summary of the
199.25 recommendations of the external contractor with whom the commissioner contracted under
199.26 Executive Order 25-10, section 1, paragraph (g), and any actions the commissioner has
199.27 taken in response to either the external contractor's recommendations or other actions taken
199.28 by the commissioner pursuant to Executive Order 25-10, section 1, paragraph (g). The
199.29 summary must be submitted to the chairs and ranking minority members of the legislative
199.30 committees with jurisdiction over health and human services policy and finance.

199.31 (d) By October 1, 2028, the commissioner must submit the external consultant's report
199.32 summarizing the evaluation and recommendations to the chairs and ranking minority
199.33 members of the legislative committees with jurisdiction over health and human services

200.1 policy and finance. The commissioner must also submit draft legislative language to
200.2 implement the recommendations of the external consultant's recommendations.

200.3 Sec. 6. **DIRECTION TO COMMISSIONER OF CHILDREN, YOUTH, AND**
200.4 **FAMILIES; HUMAN SERVICES REDESIGN STUDY.**

200.5 (a) The commissioner of children, youth, and families must prepare a study that assesses
200.6 state and local social services agency roles for administering economic assistance, child
200.7 support, and child care programs, as well as provider licensing and recipient fraud
200.8 investigation functions. The study must:

200.9 (1) identify and assess the current roles and responsibilities held by local social services
200.10 agencies and the state for oversight and administration;

200.11 (2) evaluate impacts on efficiencies, effectiveness, and outcomes associated with
200.12 county-administered and state-administered models;

200.13 (3) estimate current costs for county-administered functions and the fiscal impact of
200.14 moving to a state-administered system;

200.15 (4) analyze current financing models and resources that support county-administered
200.16 human services and the impact of shifting to a state administered model; and

200.17 (5) assess changes to policy, legal, operational, information technology, human resources,
200.18 and other areas needed to shift county-administered functions to the state.

200.19 (b) The commissioner must, at a minimum, engage with providers, advocates, and
200.20 stakeholders, including:

200.21 (1) local social services agencies;

200.22 (2) individuals and providers who have lived experience with applying for and receiving
200.23 public assistance;

200.24 (3) family child care providers that have been licensed by counties and family child care
200.25 licensing county workers; and

200.26 (4) local social service agency fraud investigators and law enforcement agencies,
200.27 including the Office of the Attorney General, the Bureau of Criminal Apprehension, and
200.28 county attorneys.

200.29 (c) Notwithstanding chapter 13 or other statute or rule to the contrary, counties must
200.30 provide financial, human resources, and other information necessary to complete the study

201.1 to the commissioner in the form, in the manner, and on the timeline requested by the
201.2 commissioner.

201.3 (d) The commissioner must submit a report on the study under this section to the chairs
201.4 and ranking minority members of the legislative committees with jurisdiction over children,
201.5 youth, and families by October 1, 2028.

201.6 ARTICLE 7
201.7 CHILDREN, YOUTH, AND FAMILIES

201.8 Section 1. **[142A.125] ELIGIBILITY TO RECEIVE PUBLIC MONEY; PRE-AWARD**
201.9 **RISK ASSESSMENT.**

201.10 Subdivision 1. **Pre-award risk assessment; grant recipients.** (a) Prior to receiving a
201.11 grant award for a program administered by the commissioner, a potential grantee must
201.12 provide the commissioner with the applicable information specified under section 16B.981,
201.13 subdivision 2, for the most recent three-year period. This information must also include:

201.14 (1) the potential grantee's history of performing services during the most recent three-year
201.15 period that are substantially similar to the services the potential grantee is seeking to receive
201.16 public funds to provide; and

201.17 (2) for a potential grantee that is a for-profit business or nonprofit organization, evidence
201.18 of registration and good standing with the secretary of state for the most recent three-year
201.19 period, if applicable.

201.20 (b) For any information not submitted to the commissioner as required under this section
201.21 because the potential grantee determined it to be inapplicable, the potential grantee must
201.22 submit documentation noting each item that was not submitted and the reason why the
201.23 potential grantee determined it was inapplicable.

201.24 Subd. 2. **Pre-award risk assessment; licensure and reenrollment.** (a) Prior to renewing
201.25 a license or reenrolling in a program administered by the commissioner, a provider, vendor,
201.26 or individual must provide the commissioner with the applicable information specified
201.27 under section 16B.981, subdivision 2, for the most recent licensure or enrollment period.

201.28 (b) Notwithstanding paragraph (a), for a provider, vendor, or individual who has been
201.29 licensed or enrolled in a program administered by the commissioner for at least three years,
201.30 the provider, vendor, or individual must provide the commissioner with the applicable
201.31 information specified under section 16B.981, subdivision 2, for the most recent three-year
201.32 period.

202.1 (c) For any information not submitted to the commissioner as required under this section
202.2 because the provider, vendor, or individual determined it to be inapplicable, the provider,
202.3 vendor, or individual must submit documentation noting each item that was not submitted
202.4 and the reason why the provider, vendor, or individual determined it was inapplicable.

202.5 Subd. 3. **Commissioner duties.** (a) The commissioner must review all information
202.6 provided under subdivisions 1 and 2 prior to awarding a grant, renewing a license, or
202.7 reenrolling a provider. For any documentation submitted to the commissioner under
202.8 subdivision 1, paragraph (b), or subdivision 2, paragraph (c), the commissioner must review
202.9 and confirm that the determination of inapplicability made by the potential grantee or the
202.10 provider, vendor, or individual is correct. For any incorrect determination, the potential
202.11 grantee or the provider, vendor, or individual must submit the required information before
202.12 receiving grant funds, renewing a license, or reenrolling in a program.

202.13 (b) Notwithstanding section 16B.981, if, after reviewing the information provided under
202.14 subdivision 1, the commissioner has concerns that there is a substantial risk that a potential
202.15 grantee cannot or would not perform the required duties under the grant agreement, the
202.16 commissioner must not award the grant.

202.17 (c) If, after reviewing the information provided under subdivision 2, the commissioner
202.18 has concerns that there is a substantial risk that the provider, vendor, or individual seeking
202.19 to renew a license or reenroll in a program administered by the commissioner cannot or
202.20 would not perform the necessary duties required under the license or enrollment agreement,
202.21 the commissioner must deny the license renewal or reenrollment request.

202.22 Sec. 2. Minnesota Statutes 2024, section 142E.16, is amended by adding a subdivision to
202.23 read:

202.24 Subd. 1a. **Training required for payments.** (a) As a condition of payment and prior to
202.25 authorization, all providers receiving child care assistance payments must complete
202.26 compliance training developed by the commissioner that addresses program integrity
202.27 requirements including but not limited to record keeping and billing requirements. The
202.28 commissioner shall develop criteria, reporting requirements, and standards for when providers
202.29 need to renew training after their initial registration.

202.30 (b) Providers that do not have an active registration to receive child care assistance on
202.31 or before April 12, 2027, must complete the training under this subdivision prior to
202.32 authorization. Providers with an active registration on or before April 12, 2027, must
202.33 complete the training under this subdivision before the provider's first renewal after April
202.34 12, 2027, or April 10, 2028, whichever is later.

203.1 **ARTICLE 8**

203.2 **MISCELLANEOUS**

203.3 Section 1. Minnesota Statutes 2024, section 245.096, is amended to read:

203.4 **245.096 CHANGES TO GRANT PROGRAMS.**

203.5 Prior to implementing any ~~substantial~~ changes to a grant funding formula disbursed
203.6 through allocations administered by the commissioner, the commissioner must provide a
203.7 report on the nature of the changes, the effect the changes will have, whether any funding
203.8 will change, and other relevant information, to the chairs and ranking minority members of
203.9 the legislative committees with jurisdiction over human services. The report must be provided
203.10 prior to the start of a regular session, and the proposed changes cannot be implemented until
203.11 after the adjournment of that regular session.

203.12 Sec. 2. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES;**
203.13 **CODIFYING THE OFFICE OF THE INSPECTOR GENERAL.**

203.14 (a) By December 1, 2026, the commissioner of human services must provide statutory
203.15 language that codifies the Department of Human Services Office of the Inspector General
203.16 to the chairs and ranking minority members of the legislative committees with jurisdiction
203.17 over human services and the nonpartisan staff from House Research Department and Senate
203.18 Counsel, Research, and Fiscal Analysis whose drafting areas include human services. The
203.19 statutory language must only contain:

203.20 (1) existing legal authority identified by the office that the office relies upon to carry
203.21 out its duties; and

203.22 (2) policies and procedures necessary for the office to carry out its existing duties.

203.23 (b) The commissioner must not include desired policy changes to the office, its structure,
203.24 or its duties within the codification language required under paragraph (a).

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