STATE OF MINNESOTA

Journal of the House

NINETY-FOURTH SESSION — 2025

THIRTY-THIRD LEGISLATIVE DAY

SAINT PAUL, MINNESOTA, THURSDAY, MAY 8, 2025

The House of Representatives convened at 11:00 a.m. and was called to order by Bjorn Olson, Speaker pro tempore.

Prayer was offered by Audrey Kingstrom, Humanist Celebrant, HumanistsMN, Minneapolis, Minnesota.

The members of the House gave the pledge of allegiance to the flag of the United States of America.

The roll was called and the following members were present:

Acomb	Dotseth	Heintzeman	Kozlowski	Norris	Skraba
Agbaje	Duran	Hemmingsen-Jaeger	Koznick	Novotny	Smith
Allen	Elkins	Her	Kraft	O'Driscoll	Stephenson
Altendorf	Engen	Hicks	Kresha	Olson	Stier
Anderson, P. E.	Falconer	Hill	Lawrence	Pérez-Vega	Swedzinski
Anderson, P. H.	Feist	Hollins	Lee, F.	Perryman	Tabke
Backer	Finke	Hortman	Lee, K.	Pinto	Torkelson
Bahner	Fischer	Howard	Liebling	Pursell	Van Binsbergen
Bakeberg	Fogelman	Hudson	Lillie	Quam	Vang
Baker	Franson	Huot	Long	Rarick	Virnig
Bennett	Frazier	Hussein	Mahamoud	Rehm	Warwas
Berg	Frederick	Igo	McDonald	Rehrauer	West
Bierman	Freiberg	Jacob	Mekeland	Repinski	Wiener
Bliss	Gander	Johnson, P.	Moller	Reyer	Witte
Burkel	Gillman	Johnson, W.	Momanyi-Hiltsley	Roach	Wolgamott
Carroll	Gomez	Jones	Mueller	Robbins	Xiong
Cha	Gordon	Jordan	Murphy	Rymer	Youakim
Clardy	Gottfried	Joy	Myers	Schomacker	Zeleznikar
Coulter	Greene	Keeler	Nadeau	Schultz	Spk. Demuth
Curran	Greenman	Klevorn	Nash	Schwartz	
Davids	Hansen, R.	Knudsen	Nelson	Scott	
Davis	Hanson, J.	Koegel	Niska	Sencer-Mura	
Dippel	Harder	Kotyza-Witthuhn	Noor	Sexton	

A quorum was present.

The Chief Clerk proceeded to read the Journal of the preceding day. There being no objection, further reading of the Journal was dispensed with and the Journal was approved as corrected by the Chief Clerk.

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PETITIONS AND COMMUNICATIONS

The following communications were received:

STATE OF MINNESOTA
OFFICE OF THE GOVERNOR
SAINT PAUL 55155

May 6, 2025

The Honorable Lisa Demuth
Speaker of the House of Representatives
The State of Minnesota

Dear Speaker Demuth:

Please be advised that I have received, approved, signed, and deposited in the Office of the Secretary of State the following House Files:

H. F. No. 1014, relating to commerce; allowing the Minnesota Insurance Guaranty Association to request financial information from insureds.

H. F. No. 1163, relating to public safety; clarifying the scope of the hometown heroes assistance program.

Sincerely,

TIM WALZ
Governor

STATE OF MINNESOTA
OFFICE OF THE SECRETARY OF STATE
ST. PAUL 55155

The Honorable Lisa Demuth
Speaker of the House of Representatives

The Honorable Bobby Joe Champion
President of the Senate

I have the honor to inform you that the following enrolled Acts of the 2025 Session of the State Legislature have been received from the Office of the Governor and are deposited in the Office of the Secretary of State for preservation, pursuant to the State Constitution, Article IV, Section 23:

S. F. No.	*H. F. No.*	*Session Laws Chapter No.*	*Time and Date Approved 2025*	*Date Filed 2025*
	1014	14	9:42 a.m. May 6	May 6
571		15	9:43 a.m. May 6	May 6
	1163	17	9:46 a.m. May 6	May 6

Sincerely,

STEVE SIMON
Secretary of State

REPORTS OF STANDING COMMITTEES AND DIVISIONS

Stephenson and Torkelson from the Committee on Ways and Means to which was referred:

H. F. No. 2435, A bill for an act relating to human services; making human services forecast adjustments; appropriating money.

Reported the same back with the following amendments:

Delete everything after the enacting clause and insert:

"ARTICLE 1
DEPARTMENT OF HEALTH FINANCE

Section 1. **[144.063] DEMENTIA SERVICES PROGRAM ESTABLISHED.**

The commissioner of health shall establish the dementia services program to:

(1) facilitate the coordination and support of:

(i) state-funded policies and programs that relate to Alzheimer's disease or related forms of dementia;

(ii) outreach programs and services between state agencies, local public health departments, Tribal Nations, educational institutions, and community groups for the purpose of fostering public awareness and education regarding Alzheimer's disease and related forms of dementia; and

(iii) services and activities between groups that are interested in dementia research, programs, and services, including area agencies on aging, service providers, advocacy groups, legal services, emergency personnel, law enforcement, local public health departments, Tribal Nations, and state colleges and universities;

(2) facilitate the coordination, review, publication, and implementation of and updates to the Alzheimer's Disease State Plan;

(3) collect and analyze data related to the impact of Alzheimer's disease in Minnesota; and

(4) incorporate early detection and risk reduction strategies into existing department-led public health programs.

Sec. 2. Minnesota Statutes 2024, section 144.0758, subdivision 3, is amended to read:

Subd. 3. **Eligible grantees.** (a) Organizations eligible to receive grant funding under this section are Minnesota's Tribal Nations in accordance with paragraph (b) and urban American Indian community-based organizations in accordance with paragraph (c).

(b) Minnesota's Tribal Nations may choose to receive funding under this section according to a noncompetitive funding formula specified by the commissioner.

(c) Urban American Indian community-based organizations are eligible to apply for funding under this section by submitting a proposal for consideration by the commissioner.

Sec. 3. Minnesota Statutes 2024, section 144.1222, subdivision 2d, is amended to read:

Subd. 2d. **~~Hot tubs~~ Spa pools on rental ~~houseboats~~ property.** (a) For purposes of this subdivision, "spa pool" has the meaning given in Minnesota Rules, part 4717.0250, subpart 9.

(b) Except as provided in paragraph (c), a ~~hot water~~ spa pool intended for seated recreational use, including a hot tub or whirlpool, that is located on ~~a houseboat that is rented to the public~~ the property of a stand-alone, single-unit rental property, offered for rent by the property owner or through a resort, and that is only intended to be used by the occupants of the rental property:

(1) is not a public pool ~~and~~;

(2) is exempt from the requirements for public pools under subdivisions 1 to 2c, 4, and 5 and Minnesota Rules, chapter 4717, except as otherwise provided in this paragraph; and

(3) may be used by renters so long as:

(i) the water temperature in the spa pool does not exceed 106 degrees Fahrenheit;

(ii) prior to check-in by each new rental party, the resort or property owner tests the water in the spa pool for the concentration of chlorine or bromine, pH, and alkalinity and the water in the spa pool meets the requirements for disinfection residual, pH, and alkalinity in Minnesota Rules, part 4717.1750, subparts 4 to 6; and

(iii) at check-in, the resort or property owner provides each rental party with a notice that there is a spa pool on the property and that the spa pool is not subject to all of the requirements in state law and rules for public pools.

~~(b)~~ (c) A spa pool intended for seated recreational use, including a hot tub or whirlpool, that is located on a houseboat that is rented to the public:

(1) is not a public pool;

(2) is exempt from the requirements for public pools under subdivisions 1 to 2c, 4, and 5 and Minnesota Rules, chapter 4717; and

(3) is exempt from the requirements under paragraph (b), clause (3).

(d) A political subdivision must not adopt a local law, rule, or ordinance that prohibits the operation of, or establishes additional requirements for, a spa pool that meets the criteria in paragraph (b) or (c).

(e) A ~~hot water~~ spa pool under this subdivision must be conspicuously posted with the following notice to renters:

"NOTICE

This spa is exempt from certain state and local sanitary requirements that prevent disease transmission.

USE AT YOUR OWN RISK

This notice is required under Minnesota Statutes, section 144.1222, subdivision 2d."

Sec. 4. **[144.124] EDUCATION ON RECOGNIZING SIGNS OF PHYSICAL ABUSE IN INFANTS.**

Subdivision 1. **Education by health care providers.** Family practice physicians, pediatricians, and other pediatric primary care providers must provide parents and primary caregivers of infants up to six months of age with materials on how to recognize the signs of physical abuse in infants and how to report suspected physical abuse of infants. These materials must be identified and approved by the commissioner of health according to subdivision 2 and must be provided to an infant's parents or primary caregivers at the infant's first well-baby visit after birth.

Subd. 2. **Materials.** The commissioner of health, in consultation with the commissioner of children, youth, and families, must identify, approve, and make available to pediatric primary care providers materials for pediatric primary care providers to use at well-baby visits to educate parents and primary caregivers of infants up to six months of age on recognizing the signs of physical abuse in infants and how to report suspected physical abuse of infants. The commissioner must make these materials available on the Department of Health website.

Sec. 5. Minnesota Statutes 2024, section 144.125, subdivision 1, is amended to read:

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

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

(c) The fee to support the newborn screening program, including tests administered under this section and section 144.966, shall be ~~$177~~ $184 per specimen. This fee amount shall be deposited in the state treasury and credited to the state government special revenue fund.

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

Sec. 6. Minnesota Statutes 2024, section 144.125, subdivision 2, is amended to read:

Subd. 2. **Determination of tests to be administered.** (a) The commissioner shall periodically revise the list of tests to be administered for determining the presence of a heritable or congenital disorder. Revisions to the list shall reflect advances in medical science, new and improved testing methods, or other factors that will improve the public health. In determining whether a test must be administered, the commissioner shall take into consideration the adequacy of analytical methods to detect the heritable or congenital disorder, the ability to treat or prevent medical

conditions caused by the heritable or congenital disorder, and the severity of the medical conditions caused by the heritable or congenital disorder. The list of tests to be performed may be revised if the changes are recommended by the advisory committee established under section 144.1255, approved by the commissioner, and published in the State Register. The revision is exempt from the rulemaking requirements in chapter 14, and sections 14.385 and 14.386 do not apply.

(b) The commissioner shall revise the list of tests to be administered for determining the presence of a heritable or congenital disorder to include metachromatic leukodystrophy (MLD).

Sec. 7. Minnesota Statutes 2024, section 144.562, subdivision 2, is amended to read:

Subd. 2. **Eligibility for license condition.** (a) A hospital is not eligible to receive a license condition for swing beds unless (1) it either has a licensed bed capacity of less than 50 beds defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66, or it has a licensed bed capacity of 50 beds or more and has swing beds that were approved for Medicare reimbursement before May 1, 1985, or it has a licensed bed capacity of less than 65 beds and the available nursing homes within 50 miles have had, in the aggregate, an average occupancy rate of 96 percent or higher in the most recent two years as documented on the statistical reports to the Department of Health; and (2) it is located in a rural area as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 482.66.

(b) Except for those critical access hospitals established under section 144.1483, clause (9), and section 1820 of the federal Social Security Act, United States Code, title 42, section 1395i-4, that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, eligible hospitals are allowed a total number of days of swing bed use per year as provided in paragraph (c). Critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, are allowed swing bed use as provided in federal law. A critical access hospital described in section 144.5621 is allowed an unlimited number of days of swing bed use per year.

(c) An eligible hospital is allowed a total of 3,000 days of swing bed use in calendar year 2020. Beginning in calendar year 2021, and for each subsequent calendar year until calendar year 2027, the total number of days of swing bed use per year is increased by 200 swing bed use days. Beginning in calendar year 2028, an eligible hospital is allowed a total of 4,500 days of swing bed use per year.

(d) Days of swing bed use for medical care that an eligible hospital has determined are charity care shall not count toward the applicable limit in paragraph (b) or (c). For purposes of this paragraph, "charity care" means care that an eligible hospital provided for free or at a discount to persons who cannot afford to pay and for which the eligible hospital did not expect payment.

(e) Days of swing bed use for care of a person who has been denied admission to every Medicare-certified skilled nursing facility within 25 miles of the eligible hospital shall not count toward the applicable limit in paragraphs (b) and (c). Eligible hospitals must maintain documentation that they have contacted each skilled nursing facility within 25 miles to determine if any skilled nursing facility beds are available and if the skilled nursing facilities are willing to admit the patient. Skilled nursing facilities that are contacted must admit the patient or deny admission within 24 hours of being contacted by the eligible hospital. Failure to respond within 24 hours is deemed a denial of admission.

~~(f) Except for critical access hospitals that have an attached nursing home or that owned a nursing home located in the same municipality as of May 1, 2005, the commissioner of health may approve swing bed use beyond 2,000 days as long as there are no Medicare certified skilled nursing facility beds available within 25 miles of that hospital that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. Critical access hospitals exceeding 2,000 swing bed days must maintain documentation that they have contacted~~

~~skilled nursing facilities within 25 miles to determine if any skilled nursing facility beds are available that are willing to admit the patient and the patient agrees to the referral being sent to the skilled nursing facility. This paragraph expires January 1, 2020.~~

~~(g) After reaching 2,000 days of swing bed use in a year, an eligible hospital to which this limit applies may admit six additional patients to swing beds each year without seeking approval from the commissioner or being in violation of this subdivision. These six swing bed admissions are exempt from the limit of 2,000 annual swing bed days for hospitals subject to this limit. This paragraph expires January 1, 2020.~~

~~(h) A health care system that is in full compliance with this subdivision may allocate its total limit of swing bed days among the hospitals within the system, provided that no hospital in the system without an attached nursing home may exceed 2,000 swing bed days per year. This paragraph expires January 1, 2020.~~

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 8. Minnesota Statutes 2024, section 144.562, subdivision 3, is amended to read:

Subd. 3. **Approval of license condition.** (a) The commissioner of health shall approve a license condition for swing beds if the hospital meets all of the criteria of this subdivision.

(b) The hospital must meet the eligibility criteria in subdivision 2.

(c) The hospital must be in compliance with the Medicare conditions of participation for swing beds under Code of Federal Regulations, title 42, section 482.66.

(d) Except as provided in section 144.5621, the hospital must agree, in writing, to limit the length of stay of a patient receiving services in a swing bed to not more than 40 days, or the duration of Medicare eligibility, unless the commissioner of health approves a greater length of stay in an emergency situation. To determine whether an emergency situation exists, the commissioner shall require the hospital to provide documentation that continued services in the swing bed are required by the patient; that no skilled nursing facility beds are available within 25 miles from the patient's home, or in some more remote facility of the resident's choice, that can provide the appropriate level of services required by the patient; and that other alternative services are not available to meet the needs of the patient. If the commissioner approves a greater length of stay, the hospital shall develop a plan providing for the discharge of the patient upon the availability of a nursing home bed or other services that meet the needs of the patient. Permission to extend a patient's length of stay must be requested by the hospital at least ten days prior to the end of the maximum length of stay.

(e) Except as provided in section 144.5621, the hospital must agree, in writing, to limit admission to a swing bed only to (1) patients who have been hospitalized and not yet discharged from the facility, or (2) patients who are transferred directly from an acute care hospital.

(f) The hospital must agree, in writing, to report to the commissioner of health by December 1, 1985, and annually thereafter, in a manner required by the commissioner (1) the number of patients readmitted to a swing bed within 60 days of a patient's discharge from the facility, (2) the hospital's charges for care in a swing bed during the reporting period with a description of the care provided for the rate charged, and (3) the number of beds used by the hospital for transitional care and similar subacute inpatient care.

(g) The hospital must agree, in writing, to report statistical data on the utilization of the swing beds on forms supplied by the commissioner. The data must include the number of swing beds, the number of admissions to and discharges from swing beds, Medicare reimbursed patient days, total patient days, and other information required by the commissioner to assess the utilization of swing beds.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 9. **[144.5621] SWING BED APPROVAL; EXCEPTIONS.**

Subdivision 1. **Swing bed exemption.** (a) The conditions and limitations in section 144.562, paragraphs (d) and (e), do not apply to any hospital located in Cook County that:

(1) is designated as a critical access hospital under section 144.1483, clause (9), and United States Code, title 42, section 1395i-4; and

(2) has an attached nursing home.

(b) Any swing bed located in a hospital described in this section may be used to provide nursing care without requiring a prior hospital stay.

(c) The nursing care provided to a patient in a swing bed is a covered medical assistance service under section 256B.0625, subdivision 2b.

Subd. 2. **Application of the health care bill of rights.** A patient in a swing bed located in a hospital described in this section is a resident of a nursing home for the purposes of section 144.651.

Subd. 3. **Comprehensive resident assessment.** A patient in a swing bed located in a hospital described in this section is a resident of a nursing home for the purposes of Minnesota Rules, part 4658.0400.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 10. Minnesota Statutes 2024, section 144.563, is amended to read:

144.563 NURSING SERVICES PROVIDED IN A HOSPITAL; PROHIBITED PRACTICES.

A hospital that has been granted a license condition under section 144.562 or 144.5621 must not provide to patients not reimbursed by Medicare or medical assistance the types of services that would be usually and customarily provided and reimbursed under medical assistance or Medicare as services of a skilled nursing facility or intermediate care facility for more than 42 days and only for patients who have been hospitalized and no longer require an acute level of care. Permission to extend a patient's length of stay may be granted by the commissioner if requested by the physician at least ten days prior to the end of the maximum length of stay.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 11. Minnesota Statutes 2024, section 144.608, subdivision 2, is amended to read:

Subd. 2. **Council administration.** (a) The council must meet at least twice a year but may meet more frequently at the call of the chair, a majority of the council members, or the commissioner.

(b) The terms, compensation, and removal of members of the council are governed by section 15.059. The council expires June 30, ~~2025~~ 2035.

(c) The council may appoint subcommittees and work groups. Subcommittees shall consist of council members. Work groups may include noncouncil members. Noncouncil members shall be compensated for work group activities under section 15.059, subdivision 3, but shall receive expenses only.

Sec. 12. Minnesota Statutes 2024, section 144.966, subdivision 2, is amended to read:

Subd. 2. **Newborn Hearing Screening Advisory Committee.** (a) The commissioner of health shall establish a Newborn Hearing Screening Advisory Committee to advise and assist the Department of Health; Department of Children, Youth, and Families; and the Department of Education in:

(1) developing protocols and timelines for screening, rescreening, and diagnostic audiological assessment and early medical, audiological, and educational intervention services for children who are deaf or hard-of-hearing;

(2) designing protocols for tracking children from birth through age three that may have passed newborn screening but are at risk for delayed or late onset of permanent hearing loss;

(3) designing a technical assistance program to support facilities implementing the screening program and facilities conducting rescreening and diagnostic audiological assessment;

(4) designing implementation and evaluation of a system of follow-up and tracking; and

(5) evaluating program outcomes to increase effectiveness and efficiency and ensure culturally appropriate services for children with a confirmed hearing loss and their families.

(b) The commissioner of health shall appoint at least one member from each of the following groups with no less than two of the members being deaf or hard-of-hearing:

(1) a representative from a consumer organization representing culturally deaf persons;

(2) a parent with a child with hearing loss representing a parent organization;

(3) a consumer from an organization representing oral communication options;

(4) a consumer from an organization representing cued speech communication options;

(5) an audiologist who has experience in evaluation and intervention of infants and young children;

(6) a speech-language pathologist who has experience in evaluation and intervention of infants and young children;

(7) two primary care providers who have experience in the care of infants and young children, one of which shall be a pediatrician;

(8) a representative from the early hearing detection intervention teams;

(9) a representative from the Department of Education resource center for the deaf and hard-of-hearing or the representative's designee;

(10) a representative of the Commission of the Deaf, DeafBlind and Hard of Hearing;

(11) a representative from the Department of Human Services Deaf and Hard-of-Hearing Services Division;

(12) one or more of the Part C coordinators from the Department of Education; the Department of Health; the Department of Children, Youth, and Families; or the Department of Human Services or the department's designees;

(13) the Department of Health early hearing detection and intervention coordinators;

(14) two birth hospital representatives from one rural and one urban hospital;

(15) a pediatric geneticist;

(16) an otolaryngologist;

(17) a representative from the Newborn Screening Advisory Committee under this subdivision;

(18) a representative of the Department of Education regional low-incidence facilitators;

(19) a representative from the deaf mentor program; and

(20) a representative of the Minnesota State Academy for the Deaf from the Minnesota State Academies staff.

The commissioner must complete the initial appointments required under this subdivision by September 1, 2007, and the initial appointments under clauses (19) and (20) by September 1, 2019.

(c) The Department of Health member shall chair the first meeting of the committee. At the first meeting, the committee shall elect a chair from its membership. The committee shall meet at the call of the chair, at least four times a year. The committee shall adopt written bylaws to govern its activities. The Department of Health shall provide technical and administrative support services as required by the committee. These services shall include technical support from individuals qualified to administer infant hearing screening, rescreening, and diagnostic audiological assessments.

Members of the committee shall receive no compensation for their service, but shall be reimbursed as provided in section 15.059 for expenses incurred as a result of their duties as members of the committee.

(d) By February 15, 2015, and by February 15 of the odd-numbered years after that date, the commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and data privacy on the activities of the committee that have occurred during the past two years.

~~(e) This subdivision expires June 30, 2025.~~

EFFECTIVE DATE. This section is effective the day following final enactment or June 30, 2025, whichever is earlier.

Sec. 13. Minnesota Statutes 2024, section 145.8811, is amended to read:

145.8811 MATERNAL AND CHILD HEALTH ADVISORY ~~TASK FORCE~~ COMMITTEE.

Subdivision 1. **Composition of ~~task force~~ committee.** The commissioner shall establish and appoint a Maternal and Child Health Advisory ~~Task Force~~ Committee consisting of 15 members who will provide equal representation from:

(1) professionals with expertise in maternal and child health services;

(2) representatives of community health boards as defined in section 145A.02, subdivision 5; and

(3) consumer representatives interested in the health of mothers and children.

No members shall be employees of the Minnesota Department of Health. Section 15.059 governs the Maternal and Child Health Advisory ~~Task Force~~ Committee. Notwithstanding section 15.059, the Maternal and Child Health Advisory ~~Task Force~~ Committee does not expire.

Subd. 2. **Duties.** The advisory ~~task force~~ committee shall meet on a regular basis to perform the following duties:

(1) review and report on the health care needs of mothers and children throughout the state of Minnesota;

(2) review and report on the type, frequency, and impact of maternal and child health care services provided to mothers and children under existing maternal and child health care programs, including programs administered by the commissioner of health;

(3) establish, review, and report to the commissioner a list of program guidelines and criteria which the advisory ~~task force~~ committee considers essential to providing an effective maternal and child health care program to low-income populations and high-risk persons and fulfilling the purposes defined in section 145.88;

(4) make recommendations to the commissioner for the use of other federal and state funds available to meet maternal and child health needs;

(5) make recommendations to the commissioner of health on priorities for funding the following maternal and child health services:

(i) prenatal, delivery, and postpartum care;

(ii) comprehensive health care for children, especially from birth through five years of age;

(iii) adolescent health services;

(iv) family planning services;

(v) preventive dental care;

(vi) special services for chronically ill and disabled children; and

(vii) any other services that promote the health of mothers and children; and

(6) establish in consultation with the commissioner statewide outcomes that will improve the health status of mothers and children.

Sec. 14. Minnesota Statutes 2024, section 256B.0625, subdivision 2, is amended to read:

Subd. 2. **Skilled and intermediate nursing care.** ~~(a)~~ Medical assistance covers skilled nursing home services and services of intermediate care facilities, including training and habilitation services, as defined in section 252.41, subdivision 3, for persons with developmental disabilities who are residing in intermediate care facilities for persons with developmental disabilities. ~~Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless (1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 15 or fewer licensed acute care beds; (2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments; (3) the patient was screened as provided by law; (4) the patient no longer requires acute care services; and (5) no nursing home beds are available within 25 miles of the facility. The commissioner shall exempt a facility from compliance with the sole community provider requirement in clause (1) if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.~~

~~(b) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if: (1) the patient's physician, advanced practice registered nurse, or physician assistant certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family; (2) no open nursing home beds are available within 25 miles of the facility; and (3) no open beds are available in any Medicare hospice program within 50 miles of the facility. The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.~~

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 15. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 2b. **Nursing care provided to a patient in a swing bed.** (a) Medical assistance must not be used to pay the costs of nursing care provided to a patient in a swing bed as defined in section 144.562, unless:

(1) the facility in which the swing bed is located is eligible as a sole community provider, as defined in Code of Federal Regulations, title 42, section 412.92, or the facility is a public hospital owned by a governmental entity with 25 or fewer licensed acute care beds;

(2) the Centers for Medicare and Medicaid Services approves the necessary state plan amendments;

(3) the patient was screened as provided by law;

(4) the patient no longer requires acute care services; and

(5) no nursing home beds are available within 25 miles of the facility.

(b) The commissioner shall exempt a facility from compliance with the sole community provider requirement in paragraph (a), clause (1), if, as of January 1, 2004, the facility had an agreement with the commissioner to provide medical assistance swing bed services.

(c) Medical assistance also covers up to ten days of nursing care provided to a patient in a swing bed if:

(1) the patient's physician, advanced practice registered nurse, or physician assistant certifies that the patient has a terminal illness or condition that is likely to result in death within 30 days and that moving the patient would not be in the best interests of the patient and patient's family;

(2) no open nursing home beds are available within 25 miles of the facility; and

(3) no open beds are available in any Medicare hospice program within 50 miles of the facility.

(d) The commissioner shall exempt any facility described under section 144.5621 from compliance with the requirements of paragraph (a), clauses (3) and (5), and paragraph (c), and medical assistance covers an unlimited number of days of nursing care provided to a patient in a swing bed at a facility described under section 144.5621.

(e) The daily medical assistance payment for nursing care for the patient in the swing bed is the statewide average medical assistance skilled nursing care per diem as computed annually by the commissioner on July 1 of each year.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 16. Minnesota Statutes 2024, section 256R.01, is amended by adding a subdivision to read:

Subd. 1a. **Payment rates for nursing care provided to a patient in a swing bed.** Payment rates paid to any hospital for nursing care provided to a patient in a swing bed must be those rates established pursuant section 256B.0625, subdivision 2b.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioners of health and human services shall inform the revisor of statutes when federal approval is obtained.

Sec. 17. **SPOKEN LANGUAGE HEALTH CARE INTERPRETER WORK GROUP.**

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

(b) "Commissioner" means the commissioner of health.

(c) "Common languages" means the 15 most common languages without regard to dialect in Minnesota.

(d) "Registered interpreter" means a spoken language interpreter who is listed on the Department of Health's spoken language health care interpreter roster.

(e) "Work group" means the spoken language health care interpreter work group established in this section.

Subd. 2. **Composition.** The commissioner, after receiving work group candidate applications, must appoint 15 members to the work group consisting of the following members:

(1) three members who are interpreters listed on the Department of Health's spoken language health care interpreter roster and who are Minnesota residents. Of these members:

(i) each must be an interpreter for a different language;

(ii) at least one must have a national certification credential; and

(iii) at least one must have been listed on the roster as an interpreter in a language other than the common languages and must have completed a nationally recognized training program for health care interpreters that is, at a minimum, 40 hours in length;

(2) three members representing limited English proficiency (LEP) individuals. Of these members, two must represent LEP individuals who are proficient in a common language other than English and one must represent LEP individuals who are proficient in a language that is not one of the common languages;

(3) one member representing a health plan company;

(4) one member who is not an interpreter and who is representing a Minnesota health system;

(5) two members representing interpreter agencies, including one member representing agencies whose main office is located outside the seven-county metropolitan area and one member representing agencies whose main office is located within the seven-county metropolitan area;

(6) one member representing the Department of Health;

(7) one member representing the Department of Human Services;

(8) one member representing an interpreter training program or postsecondary educational institution program providing interpreter courses or skills assessment;

(9) one member who is affiliated with a Minnesota-based or Minnesota chapter of a national or international organization representing interpreters; and

(10) one member who is a licensed health care provider.

Subd. 3. **Duties.** The work group must compile a list of recommendations to support and improve access to the critical health care interpreting services provided across the state, including but not limited to:

(1) changing requirements for registered and certified interpreters to reflect changing needs of the Minnesota health care community and emerging national standards of training, competency, and testing;

(2) addressing barriers for interpreters to gain access to the roster, including barriers for interpreters of languages other than common languages and interpreters in rural areas;

(3) reimbursing spoken language health care interpreting;

(4) identifying gaps in interpreter services in rural areas and recommending ways to address interpreter training and funding needs;

(5) training, certification, and continuing education programs;

(6) convening a meeting of public and private sector representatives of the spoken language health care interpreter community to identify ongoing sources of financial assistance to aid individual interpreters in meeting interpreter training and testing requirements;

(7) conducting surveys of people receiving and providing interpreter services to understand changing needs and consumer quality of care; and

(8) suggesting changes in requirements and qualifications on telehealth or remote interpreting.

Subd. 4. **Compensation; expense reimbursement.** Compensation shall be offered to work group members not being compensated for their participation in work group activities as part of their existing job duties. Work group members shall be compensated and reimbursed for expenses for work group activities under Minnesota Statutes, section 15.059, subdivision 3.

Subd. 5. **Administrative support; meeting space, meeting facilitation.** The commissioner must provide meeting space and administrative support for the work group. The commissioner may contract with a neutral independent consultant to provide this administrative support and to facilitate and lead the meetings of the work group.

Subd. 6. **Deadline for appointments.** The commissioner must appoint members to the work group by August 15, 2025.

Subd. 7. **Expiration.** The work group and this section expire on November 2, 2026, or upon submission of the report required under subdivision 9, whichever is earlier.

Subd. 8. **Initial work group meetings.** The commissioner must convene the first meeting of the work group by October 1, 2025. Prior to the first meeting, work group members must receive survey results and evidence-based research on interpreter services in Minnesota. During the first meetings, work group members must receive survey results and consult with subject matter experts, including but not limited to signed language interpreting experts, academic experts with knowledge of interpreting research, and academic health experts to address specific gaps in spoken language health care interpreting. The work group must provide a minimum of two opportunities for public comment. These opportunities shall be announced with at least four weeks' notice, with publicity in the five most common languages in Minnesota. Interpreters for those same languages shall be provided during the public comment opportunities.

Subd. 9. **Report.** By November 1, 2026, the commissioner must provide the chairs and ranking minority members of the legislative committees with jurisdiction over health care interpreter services with recommendations, including draft legislation and any statutory changes needed to implement the recommendations, to improve and support access to health care interpreting services statewide.

Sec. 18. **TITLE.**

The amendments to Minnesota Statutes, section 144.1222, subdivision 2d, in this act may be cited as the "Free the Hot Tub Act."

Sec. 19. **REPEALER.**

Minnesota Statutes 2024, section 145.361, is repealed.

ARTICLE 2
DEPARTMENT OF HEALTH POLICY

Section 1. Minnesota Statutes 2024, section 62J.51, subdivision 19a, is amended to read:

Subd. 19a. **Uniform explanation of benefits ~~document~~.** "Uniform explanation of benefits ~~document~~" means either the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered or its electronic equivalent under section 62J.581, which is sent to a patient.

Sec. 2. Minnesota Statutes 2024, section 62J.581, is amended to read:

62J.581 STANDARDS FOR MINNESOTA UNIFORM HEALTH CARE REIMBURSEMENT DOCUMENTS.

Subdivision 1. **Minnesota uniform remittance advice.** All group purchasers shall provide a uniform claim payment/advice transaction to health care providers when a claim is adjudicated. The uniform claim payment/advice transaction shall comply with section 62J.536, subdivision 1, paragraph (b), and rules adopted under section 62J.536, subdivision 2.

Subd. 2. **Minnesota uniform explanation of benefits ~~document~~.** (a) All group purchasers shall provide a uniform explanation of benefits ~~document~~ to health care patients when an explanation of benefits ~~document~~ is provided as otherwise required or permitted by law. The uniform explanation of benefits ~~document~~ shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. **Scope.** For purposes of sections 62J.50 to 62J.61, the ~~uniform claim payment/advice transaction and~~ uniform explanation of benefits ~~document~~ format specified in subdivision 4 shall apply to all health care services delivered by a health care provider or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis, such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in ~~subdivisions 1 and~~ subdivision 2 if they comply with section 62A.01, subdivisions 2 and 3.

Subd. 4. **Specifications.** (a) The uniform explanation of benefits ~~document~~ shall be provided by use of a paper document conforming to the specifications in this section or its electronic equivalent under paragraph (b).

(b) Group purchasers may make the uniform explanation of benefits available in a version that can be accessed by health care patients electronically if:

(1) the group purchaser making the uniform explanation of benefits available electronically provides health care patients the ability to choose whether to receive paper, electronic, or both paper and electronic versions of their uniform explanation of benefits;

(2) the group purchaser provides clear, readily accessible information and instructions for the patient to communicate their choice; and

(3) health care patients not responding to the opportunity to make a choice will receive at a minimum a paper uniform explanation of benefits.

(c) The commissioner, after consulting with the Administrative Uniformity Committee, shall specify the data elements and definitions for the paper uniform explanation of benefits ~~document~~. ~~The commissioner and the Administrative Uniformity Committee must consult with the Minnesota Dental Association and Delta Dental Plan of Minnesota before requiring under this section the use of a paper document for the uniform explanation of benefits document or the uniform claim payment/advice transaction for dental care services.~~ Any electronic version of the uniform explanation of benefits must use the same data elements and definitions as the paper uniform explanation of benefits.

~~Subd. 5. **Effective date.** The requirements in subdivisions 1 and 2 are effective June 30, 2007. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.~~

Sec. 3. Minnesota Statutes 2024, section 144.50, is amended by adding a subdivision to read:

Subd. 8. **Controlling person.** (a) For hospitals licensed under sections 144.50 to 144.56, "controlling person" means an owner and the following individuals and entities, if applicable:

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

(2) the hospital administrator;

(3) any managerial official; and

(4) any individual or entity who has a direct or indirect ownership interest in:

(i) any corporation, partnership, or other business association which is a controlling person;

(ii) the land on which a hospital is located;

(iii) the structure in which a hospital is located;

(iv) any entity with at least a five percent mortgage, contract for deed, deed of trust, or other security interest in the land or structure comprising a hospital; or

(v) any lease or sublease of the land, structure, or facilities comprising a hospital.

(b) "Controlling person" 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 directly or through a subsidiary operates a hospital;

(2) government and government-sponsored entities such as the United States Department of Housing and Urban Development, Ginnie Mae, Fannie Mae, Freddie Mac, and the Minnesota Housing Finance Agency which provide loans, financing, and insurance products for housing sites;

(3) an individual who is a state or federal official, a state or federal employee, or a member or employee of the governing body of a political subdivision of the state or federal government that operates one or more hospitals, unless the individual is also an officer, owner, or managerial official of the hospital, receives any remuneration from the hospital, or is a controlling person not otherwise excluded in this subdivision;

(4) an individual who is a member of a tax-exempt organization under section 290.05, subdivision 2, unless the individual is also a controlling person not otherwise excluded in this subdivision; or

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

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

(ii) whose transactions are exempt by virtue of section 80A.46, clause (7).

Sec. 4. Minnesota Statutes 2024, section 144.555, subdivision 1a, is amended to read:

Subd. 1a. **Notice of closing, curtailing operations, relocating services, or ceasing to offer certain services; hospitals.** (a) The controlling persons of a hospital licensed under sections 144.50 to 144.56 or a hospital campus must notify the commissioner of health, the public, and others at least 182 days before the hospital or hospital

campus voluntarily plans to implement one of the scheduled actions listed in paragraph (b), unless the controlling persons can demonstrate to the commissioner that meeting the advanced notice requirement is not feasible and the commissioner approves a shorter advanced notice.

(b) The following scheduled actions require advanced notice under paragraph (a):

(1) ceasing operations;

(2) curtailing operations to the extent that patients receiving inpatient health services or emergency department services must be relocated;

(3) relocating the provision of inpatient health services or emergency department services to another hospital or ~~another~~ hospital campus; or

(4) ceasing to offer inpatient maternity care and inpatient newborn care services, inpatient intensive care unit services, inpatient mental health services, or inpatient substance use disorder treatment services.

(c) A notice required under this subdivision must comply with the requirements in subdivision 1d.

(d) The commissioner shall cooperate with the controlling persons and advise them about relocating the patients.

(e) For purposes of this subdivision, "inpatient" means services provided to an individual admitted to a hospital for bed occupancy.

Sec. 5. Minnesota Statutes 2024, section 144.555, subdivision 1b, is amended to read:

Subd. 1b. **Public hearing.** Within 30 days after receiving notice under subdivision 1a, the commissioner shall conduct a public hearing on the scheduled cessation of operations, curtailment of operations, relocation of health services, or cessation in offering health services. The commissioner must provide adequate public notice of the hearing in a time and manner determined by the commissioner. The commissioner must ensure that video conferencing technology is used at the public hearing to allow members of the public to view and participate in the hearing. The controlling persons of the hospital or hospital campus must participate in the public hearing. The public hearing must be held at a location that is within ten miles of the hospital or hospital campus or with the commissioner's approval as close as is practicable, that can accommodate the hearing's anticipated public attendance, and that is provided or arranged by the hospital or hospital campus. ~~Video conferencing technology must be used to allow members of the public to view and participate in the hearing.~~ The public hearing must include:

(1) an explanation by the controlling persons of the reasons for ceasing or curtailing operations, relocating health services, or ceasing to offer any of the listed health services;

(2) a description of the actions that controlling persons will take to ensure that residents in the hospital's or campus's service area have continued access to the health services being eliminated, curtailed, or relocated;

(3) an opportunity for at least one hour of public testimony on the scheduled cessation or curtailment of operations, relocation of health services, or cessation in offering any of the listed health services, and on the hospital's or campus's plan to ensure continued access to those health services being eliminated, curtailed, or relocated; and

(4) an opportunity for the controlling persons to respond to questions from interested persons.

ARTICLE 3
HEALTH LICENSING BOARDS

Section 1. Minnesota Statutes 2024, section 144.99, subdivision 1, is amended to read:

Subdivision 1. **Remedies available.** The provisions of chapters 103I and 157 and sections 115.71 to 115.77; 144.12, subdivision 1, paragraphs (1), (2), (5), (6), (10), (12), (13), (14), and (15); 144.1201 to 144.1204; 144.121; 144.1215; 144.1222; 144.35; 144.381 to 144.385; 144.411 to 144.417; 144.495; 144.71 to 144.74; 144.9501 to 144.9512; 144.97 to 144.98; 144.992; 147.037, subdivision 1b, paragraph (d); 326.70 to 326.785; 327.10 to 327.131; and 327.14 to 327.28 and all rules, orders, stipulation agreements, settlements, compliance agreements, licenses, registrations, certificates, and permits adopted or issued by the department or under any other law now in force or later enacted for the preservation of public health may, in addition to provisions in other statutes, be enforced under this section.

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

Sec. 2. Minnesota Statutes 2024, section 147.01, subdivision 7, is amended to read:

Subd. 7. **Physician application and license fees.** (a) The board may charge the following nonrefundable application and license fees processed pursuant to sections 147.02, 147.03, 147.037, 147.0375, and 147.38:

(1) physician application fee, $200;

(2) physician annual registration renewal fee, $192;

(3) physician endorsement to other states, $40;

(4) physician emeritus license, $50;

(5) physician late fee, $60;

(6) nonrenewable 24-month limited license, $392;

(7) initial physician license for limited license holder, $192;

~~(6)~~ (8) duplicate license fee, $20;

~~(7)~~ (9) certification letter fee, $25;

~~(8)~~ (10) education or training program approval fee, $100;

~~(9)~~ (11) report creation and generation fee, $60 per hour;

~~(10)~~ (12) examination administration fee (half day), $50;

~~(11)~~ (13) examination administration fee (full day), $80;

~~(12)~~ (14) fees developed by the Interstate Commission for determining physician qualification to register and participate in the interstate medical licensure compact, as established in rules authorized in and pursuant to section 147.38, not to exceed $1,000; and

~~(13)~~ (15) verification fee, $25.

(b) The board may prorate the initial annual license fee. All licensees are required to pay the full fee upon license renewal. The revenue generated from the fee must be deposited in an account in the state government special revenue fund.

Sec. 3. Minnesota Statutes 2024, section 147.037, is amended by adding a subdivision to read:

Subd. 1b. **Limited license.** (a) A limited license under this subdivision is valid for one 24-month period and is not renewable or eligible for reapplication. The board may issue a limited license, valid for 24 months, to any person who satisfies the requirements of subdivision 1, paragraphs (a) to (c) and (e) to (g), and who:

(1) pursuant to a license or other authorization to practice, has practiced medicine, as defined in section 147.081, subdivision 3, clauses (2) to (4), for at least 60 months in the previous 12 years outside of the United States;

(2) submits sufficient evidence of an offer to practice within the context of a collaborative agreement within a hospital or clinical setting where the limited license holder and physicians work together to provide patient care;

(3) provides services in a designated rural area or underserved urban community as defined in section 144.1501; and

(4) submits two letters of recommendation in support of a limited license, which must include one letter from a physician with whom the applicant previously worked and one letter from an administrator of the hospital or clinical setting in which the applicant previously worked. The letters of recommendation must attest to the applicant's good medical standing. The board may accept alternative forms of proof that demonstrate good medical standing where there are extenuating circumstances that prevent an applicant from providing letters.

(b) For purposes of this subdivision, a person has satisfied the requirements of subdivision 1, paragraph (e), if the person has passed steps or levels one and two of the USMLE or the COMLEX-USA with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts.

(c) A person issued a limited license under this subdivision must not be required to present evidence satisfactory to the board of the completion of one year of graduate clinical medical training in a program accredited by a national accrediting organization approved by the board.

(d) An employer of a limited license holder must pay the limited license holder at least an amount equivalent to a medical resident in a comparable field. The employer must carry medical malpractice insurance covering a limited license holder for the duration of the employment. The commissioner of health may issue a correction order under section 144.99, subdivision 3, requiring an employer to comply with this paragraph. An employer must not retaliate against or discipline an employee for raising a complaint or pursuing enforcement relating to this paragraph.

(e) The board may issue a full and unrestricted license to practice medicine to a person who holds a limited license issued pursuant to paragraph (a) and who has:

(1) held the limited license for two years and is in good standing to practice medicine in this state;

(2) practiced for a minimum of 1,692 hours per year for each of the previous two years;

(3) submitted a letter of recommendation in support of a full and unrestricted license containing all attestations required under paragraph (i) from any physician who participated in the collaborative agreement;

(4) passed steps or levels one, two, and three of the USMLE or COMLEX-USA with passing scores as recommended by the USMLE program or National Board of Osteopathic Medical Examiners within three attempts; and

(5) completed 20 hours of continuing medical education.

(f) A limited license holder must submit to the board, every six months or upon request, a statement certifying whether the person is still employed as a physician in this state and whether the person has been subjected to professional discipline as a result of the person's practice. The board may suspend or revoke a limited license if a majority of the board determines that the limited license holder is no longer employed as a physician in this state by an employer. The limited license holder must be granted an opportunity to be heard prior to the board's determination. Upon request by the limited license holder, the limited license holder may have 90 days to regain employment. A limited license holder may change employers during the duration of the limited license if the limited license holder has another offer of employment. In the event that a change of employment occurs, the limited license holder must still work the number of hours required under paragraph (e), clause (2), to be eligible for a full and unrestricted license to practice medicine.

(g) In addition to any other remedy provided by law, the board may, without a hearing, temporarily suspend the license of a limited license holder if the board finds that the limited license holder has violated a statute or rule that the board is empowered to enforce and continued practice by the limited license holder would create a serious risk of harm to the public. The suspension takes effect upon written notice to the limited license holder, specifying the statute or rule violated. The suspension remains in effect until the board issues a final order in the matter after a hearing. At the time it issues the suspension notice, the board shall schedule a disciplinary hearing to be held pursuant to the Administrative Procedure Act. The limited license holder shall be provided with at least 20 days' notice of any hearing held pursuant to this subdivision. The hearing shall be scheduled to begin no later than 30 days after the issuance of the suspension order.

(h) For purposes of this subdivision, "collaborative agreement" means a mutually agreed upon plan for the overall working relationship and collaborative arrangement between a holder of a limited license and one or more physicians licensed under this chapter that designates the scope of services that can be provided to manage the care of patients. The limited license holder and one of the collaborating physicians must have experience in providing care to patients with the same or similar medical conditions. Under the collaborative agreement, the limited license holder must shadow the collaborating physician for four weeks, after which time the limited license holder must staff all patient encounters with the collaborating physician for an additional four weeks. After eight weeks, the collaborating physician has discretion to allow the limited license holder to see patients independently and may, at the discretion of the collaborating physician, require the limited license holder to present patients. However, the limited license holder must be supervised by the collaborating physician for a minimum of two hours per week. A limited license holder may practice medicine without a collaborating physician physically present, but the limited license holder and collaborating physicians must be able to easily contact each other by radio, telephone, or other telecommunication device while the limited license holder practices medicine. The limited license holder must have one-on-one practice reviews with each collaborating physician, provided in person or through eye-to-eye electronic media while maintaining visual contact, for at least two hours per week.

(i) At least one collaborating physician must submit a letter to the board, after the limited license holder has practiced under the license for 12 months, attesting to the following:

(1) the limited license holder has a basic understanding of federal and state laws regarding the provision of health care, including but not limited to:

(i) medical licensing obligations and standards; and

(ii) the Health Insurance Portability and Accountability Act, Public Law 104-191;

(2) the limited license holder has a basic understanding of documentation standards;

(3) the limited license holder has a thorough understanding of which medications are available and unavailable in the United States;

(4) the limited license holder has a thorough understanding of American medical standards of care;

(5) the limited license holder has demonstrated mastery of each of the following:

(i) gathering a history and performing a physical exam;

(ii) developing and prioritizing a differential diagnosis following a clinical encounter and selecting a working diagnosis;

(iii) recommending and interpreting common diagnostic and screening tests;

(iv) entering and discussing orders and prescriptions;

(v) providing an oral presentation of a clinical encounter;

(vi) giving a patient handover to transition care responsibly;

(vii) recognizing a patient requiring urgent care and initiating an evaluation; and

(viii) obtaining informed consent for tests, procedures, and treatments; and

(6) the limited license holder is providing appropriate medical care.

(j) The board must not grant a license under this section unless the applicant possesses federal immigration status that allows the applicant to practice as a physician in the United States.

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

Sec. 4. Minnesota Statutes 2024, section 147D.03, subdivision 1, is amended to read:

Subdivision 1. **General.** Within the meaning of sections 147D.01 to 147D.27, a person who shall publicly profess to be a traditional midwife and who, for a fee, shall assist or attend to a woman in pregnancy, childbirth outside a hospital, and postpartum, shall be regarded as practicing traditional midwifery. Effective July 1, 2026, a certified midwife licensed by the Board of Nursing under chapter 148G is not subject to the provisions of this chapter.

Sec. 5. Minnesota Statutes 2024, section 148.241, is amended to read:

148.241 EXPENSES.

Subdivision 1. **Appropriation.** The expenses of administering sections 148.171 to 148.285 and chapter 148G shall be paid from the appropriation made to the Minnesota Board of Nursing.

Subd. 2. **Expenditure.** All amounts appropriated to the board shall be held subject to the order of the board to be used only for the purpose of meeting necessary expenses incurred in the performance of the purposes of sections 148.171 to 148.285 and chapter 148G, and the duties imposed thereby as well as the promotion of nursing or certified midwifery education and standards of nursing or certified midwifery care in this state.

Sec. 6. **[148G.01] TITLE.**

This chapter shall be referred to as the "Minnesota Certified Midwife Practice Act."

Sec. 7. **[148G.02] SCOPE; EFFECTIVE DATE.**

This chapter is effective July 1, 2026, and applies to all applicants and licensees, all persons who use the title certified midwife, and all persons in or out of this state who provide certified midwifery services to patients who reside in this state, unless there are specific applicable exemptions provided by law.

Sec. 8. **[148G.03] DEFINITIONS.**

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

Subd. 2. **Board.** "Board" means the Minnesota Board of Nursing.

Subd. 3. **Certification.** "Certification" means the formal recognition by the American Midwifery Certification Board of the knowledge, skills, and experience demonstrated by the achievement of standards identified by the American College of Nurse Midwives or any successor organization.

Subd. 4. **Certified midwife.** "Certified midwife" means an individual who holds a current and valid national certification as a certified midwife from the American Midwifery Certification Board or any successor organization, and who is licensed by the board under this chapter.

Subd. 5. **Certified midwifery practice.** "Certified midwifery practice" means:

(1) managing, diagnosing, and treating women's primary health care beginning in adolescence, including pregnancy, childbirth, postpartum period, care of the newborn, family planning, partner care management relating to sexual health, and gynecological care of women;

(2) ordering, performing, supervising, and interpreting diagnostic studies within the scope of certified midwifery practice, excluding:

(i) interpreting and performing specialized ultrasound examinations; and

(ii) interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography;

(3) prescribing pharmacologic and nonpharmacologic therapies appropriate to midwifery practice;

(4) consulting with, collaborating with, or referring to other health care providers as warranted by the needs of the patient; and

(5) performing the role of educator in the theory and practice of midwifery.

Subd. 6. **Collaborating.** "Collaborating" means the process in which two or more health care professionals work together to meet the health care needs of a patient, as warranted by the needs of the patient.

Subd. 7. **Consulting.** "Consulting" means the process in which a certified midwife who maintains primary management responsibility for a patient's care seeks advice or opinion of a physician, an advanced practice registered nurse, or another member of the health care team.

Subd. 8. **Encumbered.** "Encumbered" means:

(1) a license or other credential that is revoked, is suspended, or contains limitations on the full and unrestricted practice of certified midwifery when the revocation, suspension, or limitation is imposed by a state licensing board or other state regulatory entity; or

(2) a license or other credential that is voluntarily surrendered.

Subd. 9. **Licensure period.** "Licensure period" means the interval of time during which the certified midwife is authorized to engage in certified midwifery. The initial licensure period is from six to 29 full calendar months starting on the day of licensure and ending on the last day of the certified midwife's month of birth in an even-numbered year if the year of birth is an even-numbered year, or in an odd-numbered year if the year of birth is in an odd-numbered year. Subsequent licensure renewal periods are 24 months. For licensure renewal, the period starts on the first day of the month following expiration of the previous licensure period. The period ends the last day of the certified midwife's month of birth in an even- or odd-numbered year according to the certified midwife's year of birth.

Subd. 10. **Licensed practitioner.** "Licensed practitioner" means a physician licensed under chapter 147, an advanced practice registered nurse licensed under sections 148.171 to 148.235, or a certified midwife licensed under this chapter.

Subd. 11. **Midwifery education program.** "Midwifery education program" means a program of theory and practice, offered by a university or college, that leads to the preparation and eligibility for certification in midwifery and is accredited by the Accreditation Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation.

Subd. 12. **Patient.** "Patient" means a recipient of care provided by a certified midwife within the scope of certified midwifery practice, including an individual, family, group, or community.

Subd. 13. **Prescribing.** "Prescribing" means the act of generating a prescription for the preparation of, use of, or manner of using a drug or therapeutic device under section 148G.09. Prescribing does not include recommending the use of a drug or therapeutic device that is not required by the federal Food and Drug Administration to meet the labeling requirements for prescription drugs and devices.

Subd. 14. **Prescription.** "Prescription" means a written direction or an oral direction reduced to writing provided to or for a patient for the preparation or use of a drug or therapeutic device. The requirements of section 151.01, subdivisions 16, 16a, and 16b, apply to prescriptions for drugs.

Subd. 15. **Referral.** "Referral" means the process in which a certified midwife directs a patient to a physician or another health care professional for management of a particular problem or aspect of the patient's care.

Subd. 16. **Supervision.** "Supervision" means monitoring and establishing the initial direction of, setting expectations for, directing activities in, evaluating, and changing a course of action in certified midwifery care.

Sec. 9. **[148G.04] CERTIFIED MIDWIFE LICENSING.**

Subdivision 1. **Licensure.** (a) No person shall practice as a certified midwife or serve as the faculty of record for clinical instruction in a midwifery distance learning program unless the person is licensed by the board under this chapter.

(b) An applicant for a license to practice as a certified midwife must apply to the board in a format prescribed by the board and pay a fee in an amount determined under section 148G.11.

(c) To be eligible for licensure, an applicant must:

(1) not hold an encumbered license or other credential as a certified midwife or equivalent professional designation in any state or territory;

(2) hold a current and valid certification as a certified midwife from the American Midwifery Certification Board or any successor organization acceptable to the board and provide primary source verification of certification to the board in a format prescribed by the board;

(3) have completed a graduate level midwifery education program that includes clinical experience, is accredited by the Accreditation Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation, and leads to a graduate degree. The applicant must submit primary source verification of program completion to the board in a format prescribed by the board. The primary source verification must verify the applicant completed three separate graduate-level courses in physiology and pathophysiology; advanced health assessment; and advanced pharmacology, including pharmacodynamics, pharmacokinetics, and pharmacotherapeutics of all broad categories of agents;

(4) report any criminal conviction, nolo contendere plea, Alford plea, or other plea arrangement in lieu of conviction; and

(5) not have committed any acts or omissions that are grounds for disciplinary action in another jurisdiction or, if these acts were committed and would be grounds for disciplinary action as set forth in section 148G.13, the board has found after an investigation that sufficient remediation was made.

Subd. 2. **Clinical practice component.** If more than five years have elapsed since the applicant has practiced in the certified midwife role, the applicant must complete a reorientation plan as a certified midwife. The plan must include supervision during the clinical component by a licensed practitioner with experience in providing care to patients with the same or similar health care needs. The applicant must submit the plan and the name of the practitioner to the board. The plan must include a minimum of 500 hours of supervised certified midwifery practice. The certified midwife must submit verification of completion of the clinical reorientation to the board when the reorientation is complete.

Sec. 10. **[148G.05] LICENSURE RENEWAL; RELICENSURE.**

Subdivision 1. **Renewal; current applicants.** (a) A certified midwife must apply for renewal of the certified midwife's license before the certified midwife's licensure period ends. To be considered timely, the board must receive the certified midwife's application on or before the last day of the certified midwife's licensure period. A certified midwife's license lapses if the certified midwife's application is untimely.

(b) An applicant for license renewal must provide the board evidence of current certification or recertification as a certified midwife by the American Midwifery Certification Board or any successor organization.

(c) An applicant for license renewal must submit to the board the fee under section 148G.11, subdivision 2.

Subd. 2. **Clinical practice component.** If more than five years have elapsed since the applicant has practiced as a certified midwife, the applicant must complete a reorientation plan as a certified midwife. The plan must include supervision during the clinical component by a licensed practitioner with experience in providing care to patients with the same or similar health care needs. The licensee must submit the plan and the name of the

practitioner to the board. The plan must include a minimum of 500 hours of supervised certified midwifery practice. The certified midwife must submit verification of completion of the clinical reorientation to the board when the reorientation is complete.

Subd. 3. **Relicensure; lapsed applicants.** A person whose license has lapsed and who desires to resume practice as a certified midwife must apply for relicensure, submit to the board satisfactory evidence of compliance with the procedures and requirements established by the board, and pay the board the relicensure fee under section 148G.11, subdivision 4, for the current licensure period. A penalty fee under section 148G.11, subdivision 4, is required from a person who practiced certified midwifery without current licensure. The board must relicense a person who meets the requirements of this subdivision.

Sec. 11. **[148G.06] FAILURE OR REFUSAL TO PROVIDE INFORMATION.**

Subdivision 1. **Notification requirement.** An individual licensed as a certified midwife must notify the board when the individual renews their certification. If a licensee fails to provide notification, the licensee is prohibited from practicing as a certified midwife.

Subd. 2. **Denial of license.** Refusal of an applicant to supply information necessary to determine the applicant's qualifications, failure to demonstrate qualifications, or failure to satisfy the requirements for a license contained in this chapter or rules of the board may result in denial of a license. The burden of proof is upon the applicant to demonstrate the qualifications and satisfaction of the requirements.

Sec. 12. **[148G.07] NAME CHANGE AND CHANGE OF ADDRESS.**

A certified midwife must maintain a current name and address with the board and must notify the board in writing within 30 days of any change in name or address. All notices or other correspondence mailed to or served upon a certified midwife by the board at the licensee's address on file with the board are considered received by the licensee.

Sec. 13. **[148G.08] IDENTIFICATION OF CERTIFIED MIDWIVES.**

Only those persons who hold a current license to practice certified midwifery in this state may use the title of certified midwife. A certified midwife licensed by the board must use the designation of "CM" for professional identification and in documentation of services provided.

Sec. 14. **[148G.09] PRESCRIBING DRUGS AND THERAPEUTIC DEVICES.**

Subdivision 1. **Diagnosing, prescribing, and ordering.** Certified midwives, within the scope of certified midwifery practice, are authorized to:

(1) diagnose, prescribe, and institute therapy or referrals of patients to health care agencies and providers;

(2) prescribe, procure, sign for, record, administer, and dispense over-the-counter, legend, and controlled substances, including sample drugs; and

(3) plan and initiate a therapeutic regimen that includes ordering and prescribing durable medical devices and equipment, nutrition, diagnostic services, and supportive services, including but not limited to home health care, physical therapy, and occupational therapy.

Subd. 2. **Drug Enforcement Administration requirements.** (a) Certified midwives must:

(1) comply with federal Drug Enforcement Administration (DEA) requirements related to controlled substances; and

(2) file the certified midwife's DEA registrations and numbers, if any, with the board.

(b) The board must maintain current records of all certified midwives with a DEA registration and number.

Sec. 15. **[148G.10] FEES.**

The fees specified in section 148G.11 are nonrefundable and must be deposited in the state government special revenue fund.

Sec. 16. **[148G.11] FEE AMOUNTS.**

Subdivision 1. **Licensure.** The fee for licensure is $105.

Subd. 2. **Renewal.** The fee for licensure renewal is $85.

Subd. 3. **Practicing without current certification.** The penalty fee for a person who practices certified midwifery without a current certification or recertification, or who practices certified midwifery without current certification or recertification on file with the board, is $200 for the first month or part of a month and an additional $100 for each subsequent month or parts of months of practice. The penalty fee must be calculated from the first day the certified midwife practiced without a current certification to the last day of practice without a current certification, or from the first day the certified midwife practiced without a current certification or recertification on file with the board until the day the current certification or recertification is filed with the board.

Subd. 4. **Relicensure.** The fee for relicensure is $105. The fee for practicing without current licensure is two times the amount of the current renewal fee for any part of the first calendar month, plus the current renewal fee for any part of each subsequent month up to 24 months.

Subd. 5. **Dishonored check fee.** The service fee for a dishonored check is as provided in section 604.113.

Sec. 17. **[148G.12] APPROVED MIDWIFERY EDUCATION PROGRAM.**

Subdivision 1. **Initial approval.** A university or college desiring to conduct a certified midwifery education program must submit evidence to the board that the university or college is prepared to:

(1) provide a program of theory and practice in certified midwifery leading to eligibility for certification in midwifery;

(2) achieve preaccreditation and eventual full accreditation by the American Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the Council for Higher Education Accreditation. Instruction and required experience may be obtained in one or more institutions or agencies outside the applying university or college if the program retains accountability for all clinical and nonclinical teaching; and

(3) meet other standards established by law and by the board.

Subd. 2. **Continuing approval.** The board must, through the board's representative, annually survey all midwifery education programs in the state for current accreditation status by the American Commission for Midwifery Education or any successor organization recognized by the United States Department of Education or the

Council for Higher Education Accreditation. If the results of the survey show that a certified midwifery education program meets all standards for continuing accreditation, the board must continue approval of the certified midwifery education program.

Subd. 3. **Loss of approval.** If the board determines that an accredited certified midwifery education program is not maintaining the standards required by the American Commission on Midwifery Education or any successor organization, the board must obtain the defect in writing from the accrediting body. If a program fails to correct the defect to the satisfaction of the accrediting body and the accrediting body revokes the program's accreditation, the board must remove the program from the list of approved certified midwifery education programs.

Subd. 4. **Reinstatement of approval.** The board must reinstate approval of a certified midwifery education program upon submission of satisfactory evidence that the certified midwifery education program of theory and practice meets the standards required by the accrediting body.

Sec. 18. **[148G.13] GROUNDS FOR DISCIPLINARY ACTION.**

Subdivision 1. **Grounds listed.** The board may deny, revoke, suspend, limit, or condition the license of any person to practice certified midwifery under this chapter or otherwise discipline a licensee or applicant as described in section 148G.14. The following are grounds for disciplinary action:

(1) failure to demonstrate the qualifications or satisfy the requirements for a license contained in this chapter or rules of the board. In the case of an applicant for licensure, the burden of proof is upon the applicant to demonstrate the qualifications or satisfaction of the requirements;

(2) employing fraud or deceit in procuring or attempting to procure a license to practice certified midwifery;

(3) conviction of a felony or gross misdemeanor reasonably related to the practice of certified midwifery. Conviction, as used in this subdivision, includes a conviction of an offense that if committed in this state would be considered a felony or gross misdemeanor without regard to its designation elsewhere, or a criminal proceeding where a finding or verdict of guilt is made or returned, but the adjudication of guilt is either withheld or not entered;

(4) revocation, suspension, limitation, conditioning, or other disciplinary action against the person's certified midwife credential in another state, territory, or country; failure to report to the board that charges regarding the person's certified midwifery license, certification, or other credential are pending in another state, territory, or country; or failure to report to the board having been refused a license or other credential by another state, territory, or country;

(5) failure or inability to practice as a certified midwife with reasonable skill and safety, or departure from or failure to conform to standards of acceptable and prevailing certified midwifery, including failure of a certified midwife to adequately supervise or monitor the performance of acts by any person working at the certified midwife's direction;

(6) engaging in unprofessional conduct, including but not limited to a departure from or failure to conform to statutes relating to certified midwifery practice or to the minimal standards of acceptable and prevailing certified midwifery practice, or engaging in any certified midwifery practice that may create unnecessary danger to a patient's life, health, or safety. Actual injury to a patient need not be established under this clause;

(7) supervision or accepting the supervision of a midwifery function or a prescribed health care function when the acceptance could reasonably be expected to result in unsafe or ineffective patient care;

(8) actual or potential inability to practice certified midwifery with reasonable skill and safety to patients by reason of illness; by reason of the use of alcohol, drugs, chemicals, or any other material; or as a result of any mental or physical condition;

(9) adjudication as mentally incompetent, mentally ill, a chemically dependent person, or a person dangerous to the public by a court of competent jurisdiction, within or outside of this state;

(10) engaging in any unethical conduct, including but not limited to conduct likely to deceive, defraud, or harm the public, or demonstrating a willful or careless disregard for the health, welfare, or safety of a patient. Actual injury need not be established under this clause;

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

(12) obtaining money, property, or services from a patient, other than reasonable fees for services provided to the patient, through the use of undue influence, harassment, duress, deception, or fraud;

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

(14) engaging in abusive or fraudulent billing practices, including violations of federal Medicare and Medicaid laws or state medical assistance laws;

(15) improper management of patient records, including failure to maintain adequate patient records, to comply with a patient's request made pursuant to sections 144.291 to 144.298, or to furnish a patient record or report required by law;

(16) knowingly aiding, assisting, advising, or allowing an unlicensed person to engage in the unlawful practice of certified midwifery;

(17) violating a rule adopted by the board, an order of the board, a state or federal law relating to the practice of certified midwifery, or a state or federal narcotics or controlled substance law;

(18) knowingly providing false or misleading information to a patient that is directly related to the care of that patient unless done for an accepted therapeutic purpose such as the administration of a placebo;

(19) aiding suicide or aiding attempted suicide in violation of section 609.215 as established by any of the following:

(i) a copy of the record of criminal conviction or plea of guilty for a felony in violation of section 609.215, subdivision 1 or 2;

(ii) a copy of the record of a judgment of contempt of court for violating an injunction issued under section 609.215, subdivision 4;

(iii) a copy of the record of a judgment assessing damages under section 609.215, subdivision 5; or

(iv) a finding by the board that the person violated section 609.215, subdivision 1 or 2. The board must investigate any complaint of a violation of section 609.215, subdivision 1 or 2;

(20) practicing outside the scope of certified midwifery practice as defined under section 148G.03, subdivision 5;

(21) making a false statement or knowingly providing false information to the board, failing to make reports as required by section 148G.15, or failing to cooperate with an investigation of the board as required by section 148G.17;

(22) engaging in false, fraudulent, deceptive, or misleading advertising;

(23) failure to inform the board of the person's certification or recertification status as a certified midwife;

(24) engaging in certified midwifery practice without a license and current certification or recertification by the American Midwifery Certification Board or any successor organization; or

(25) failure to maintain appropriate professional boundaries with a patient. A certified midwife must not engage in practices that create an unacceptable risk of patient harm or of the impairment of a certified midwife's objectivity or professional judgment. A certified midwife must not act or fail to act in a way that, as judged by a reasonable and prudent certified midwife, inappropriately encourages the patient to relate to the certified midwife outside of the boundaries of the professional relationship, or in a way that interferes with the patient's ability to benefit from certified midwife services. A certified midwife must not use the professional relationship with a patient, student, supervisee, or intern to further the certified midwife's personal, emotional, financial, sexual, religious, political, or business benefit or interests.

Subd. 2. **Conviction of a felony-level criminal sexual offense.** (a) Except as provided in paragraph (e), the board must not grant or renew a license to practice certified midwifery to any person who has been convicted on or after August 1, 2014, of any of the provisions of section 609.342, subdivision 1 or 1a; 609.343, subdivision 1 or 1a; 609.344, subdivision 1 or 1a, paragraphs (c) to (g); or 609.345, subdivision 1 or 1a, paragraphs (c) to (g); or a similar statute in another jurisdiction.

(b) A license to practice certified midwifery is automatically revoked if the licensee is convicted of an offense listed in paragraph (a).

(c) A license to practice certified midwifery that has been denied or revoked under this subdivision is not subject to chapter 364.

(d) For purposes of this subdivision, "conviction" means a plea of guilty, a verdict of guilty by a jury, or a finding of guilty by the court, unless the court stays imposition or execution of the sentence and final disposition of the case is accomplished at a nonfelony level.

(e) The board may establish criteria whereby an individual convicted of an offense listed in paragraph (a) may become licensed if the criteria:

(1) utilize a rebuttable presumption that the applicant is not suitable for licensing;

(2) provide a standard for overcoming the presumption; and

(3) require that a minimum of ten years has elapsed since the applicant's sentence was discharged.

(f) The board must not consider an application under paragraph (e) if the board determines that the victim involved in the offense was a patient or a client of the applicant at the time of the offense.

Subd. 3. **Evidence.** In disciplinary actions alleging a violation of subdivision 1, clause (3) or (4), or 2, a copy of the judgment or proceeding under the seal of the court administrator or of the administrative agency that entered the same is admissible into evidence without further authentication and constitutes prima facie evidence of the violation concerned.

Subd. 4. **Examination; access to medical data.** (a) If the board has probable cause to believe that grounds for disciplinary action exist under subdivision 1, clause (8) or (9), it may direct the applicant or certified midwife to submit to a mental or physical examination or chemical dependency evaluation. For the purpose of this subdivision, when a certified midwife licensed under this chapter is directed in writing by the board to submit to a mental or physical examination or chemical dependency evaluation, that person is considered to have consented and to have waived all objections to admissibility on the grounds of privilege. Failure of the applicant or certified midwife to submit to an examination when directed constitutes an admission of the allegations against the applicant or certified midwife, unless the failure was due to circumstances beyond the person's control, and the board may enter a default and final order without taking testimony or allowing evidence to be presented. A certified midwife affected under this paragraph must, at reasonable intervals, be given an opportunity to demonstrate that the competent practice of certified midwifery can be resumed with reasonable skill and safety to patients. Neither the record of proceedings nor the orders entered by the board in a proceeding under this paragraph may be used against a certified midwife in any other proceeding.

(b) Notwithstanding sections 13.384, 144.651, and 595.02, or any other law limiting access to medical or other health data, the board may obtain medical data and health records relating to a certified midwife or applicant for a license without that person's consent if the board has probable cause to believe that grounds for disciplinary action exist under subdivision 1, clause (8) or (9). The medical data may be requested from a provider, as defined in section 144.291, subdivision 2; an insurance company; or a government agency, including the Department of Human Services or Direct Care and Treatment. A provider, insurance company, or government agency must comply with any written request of the board under this subdivision and is not liable in any action for damages for releasing the data requested by the board if the data are released pursuant to a written request under this subdivision, unless the information is false and the provider giving the information knew or had reason to believe the information was false. Information obtained under this subdivision is classified as private data on individuals as defined in section 13.02.

Sec. 19. **[148G.14] FORMS OF DISCIPLINARY ACTION; AUTOMATIC SUSPENSION; TEMPORARY SUSPENSION; REISSUANCE.**

Subdivision 1. **Forms of disciplinary action.** If the board finds that grounds for disciplinary action exist under section 148G.13, it may take one or more of the following actions:

(1) deny the license application or application for license renewal;

(2) revoke the license;

(3) suspend the license;

(4) impose limitations on the certified midwife's practice of certified midwifery, including but not limited to limitation of scope of practice or the requirement of practice under supervision;

(5) impose conditions on the retention of the license, including but not limited to the imposition of retraining or rehabilitation requirements or the conditioning of continued practice on demonstration of knowledge or skills by appropriate examination, monitoring, or other review;

(6) impose a civil penalty not exceeding $10,000 for each separate violation. The amount of the civil penalty must be fixed so as to deprive the certified midwife of any economic advantage gained by reason of the violation charged; to reimburse the board for the cost of counsel, investigation, and proceeding; and to discourage repeated violations;

(7) order the certified midwife to provide unremunerated service;

(8) censure or reprimand the certified midwife; or

(9) any other action justified by the facts in the case.

Subd. 2. **Automatic suspension of license.** (a) Unless the board orders otherwise, a license to practice certified midwifery is automatically suspended if:

(1) a guardian of a certified midwife is appointed by order of a court under sections 524.5-101 to 524.5-502;

(2) the certified midwife is committed by order of a court under chapter 253B; or

(3) the certified midwife is determined to be mentally incompetent, mentally ill, chemically dependent, or a person dangerous to the public by a court of competent jurisdiction within or outside of this state.

(b) The license remains suspended until the certified midwife is restored to capacity by a court and, upon petition by the certified midwife, the suspension is terminated by the board after a hearing or upon agreement between the board and the certified midwife.

Subd. 3. **Temporary suspension of license.** In addition to any other remedy provided by law, the board may, through its designated board member under section 214.10, subdivision 2, temporarily suspend the license of a certified midwife without a hearing if the board finds that there is probable cause to believe the certified midwife has violated a statute or rule the board is empowered to enforce and continued practice by the certified midwife would create a serious risk of harm to others. The suspension takes effect upon written notice to the certified midwife, served by first-class mail, specifying the statute or rule violated. The suspension must remain in effect until the board issues a temporary stay of suspension or a final order in the matter after a hearing or upon agreement between the board and the certified midwife. At the time it issues the suspension notice, the board must schedule a disciplinary hearing to be held under the Administrative Procedure Act. The board must provide the certified midwife at least 20 days' notice of any hearing held under this subdivision. The board must schedule the hearing to begin no later than 30 days after the issuance of the suspension order.

Subd. 4. **Reissuance.** The board may reinstate and reissue a license to practice certified midwifery, but as a condition may impose any disciplinary or corrective measure that it might originally have imposed. Any person whose license has been revoked, suspended, or limited may have the license reinstated and a new license issued when, at the discretion of the board, the action is warranted, provided that the board must require the person to pay the costs of the proceedings resulting in the revocation, suspension, or limitation of the license; the relicensure fee; and the fee for the current licensure period. The cost of proceedings includes but is not limited to the cost paid by the board to the Office of Administrative Hearings and the Office of the Attorney General for legal and investigative services; the costs of a court reporter and witnesses, reproduction of records, board staff time, travel, and expenses; and the costs of board members' per diem reimbursements, travel costs, and expenses.

Sec. 20. **[148G.15] REPORTING OBLIGATIONS.**

Subdivision 1. **Permission to report.** A person who has knowledge of any conduct constituting grounds for discipline under section 148G.13 may report the alleged violation to the board.

Subd. 2. **Institutions.** The chief nursing executive or chief administrative officer of any hospital, clinic, prepaid medical plan, or other health care institution or organization located in this state must report to the board any action taken by the institution or organization or any of its administrators or committees to revoke, suspend, limit, or condition a certified midwife's privilege to practice in the institution, or as part of the organization, any denial of privileges, any dismissal from employment, or any other disciplinary action. The institution or organization must also report the resignation of any certified midwife before the conclusion of any disciplinary proceeding, or before commencement of formal charges, but after the certified midwife had knowledge that formal charges were contemplated or in preparation. The reporting described by this subdivision is required only if the action pertains to grounds for disciplinary action under section 148G.13.

Subd. 3. **Licensed professionals.** A person licensed by a health-related licensing board as defined in section 214.01, subdivision 2, must report to the board personal knowledge of any conduct the person reasonably believes constitutes grounds for disciplinary action under section 148G.13 by any certified midwife, including conduct indicating that the certified midwife may be incompetent, may have engaged in unprofessional or unethical conduct, or may be mentally or physically unable to engage safely in the practice of certified midwifery.

Subd. 4. **Insurers.** (a) By the first day of February, May, August, and November, each insurer authorized to sell insurance described in section 60A.06, subdivision 1, clause (13), and providing professional liability insurance to certified midwives must submit to the board a report concerning any certified midwife against whom a malpractice award has been made or who has been a party to a settlement. The report must contain at least the following information:

(1) the total number of settlements or awards;

(2) the date a settlement or award was made;

(3) the allegations contained in the claim or complaint leading to the settlement or award;

(4) the dollar amount of each malpractice settlement or award and whether that amount was paid as a result of a settlement or of an award; and

(5) the name and address of the practice of the certified midwife against whom an award was made or with whom a settlement was made.

(b) An insurer must also report to the board any information it possesses that tends to substantiate a charge that a certified midwife may have engaged in conduct in violation of this chapter.

Subd. 5. **Courts.** The court administrator of district court or another court of competent jurisdiction must report to the board any judgment or other determination of the court that adjudges or includes a finding that a certified midwife is a person who is mentally ill, mentally incompetent, chemically dependent, dangerous to the public, guilty of a felony or gross misdemeanor, guilty of a violation of federal or state narcotics laws or controlled substances act, guilty of operating a motor vehicle while under the influence of alcohol or a controlled substance, or guilty of an abuse or fraud under Medicare or Medicaid; or if the court appoints a guardian of the certified midwife under sections 524.5-101 to 524.5-502 or commits a certified midwife under chapter 253B.

Subd. 6. **Deadlines; forms.** Reports required by subdivisions 2, 3, and 5 must be submitted no later than 30 days after the occurrence of the reportable event or transaction. The board may provide forms for the submission of reports required by this section, may require that the reports be submitted on the forms provided, and may adopt rules necessary to ensure prompt and accurate reporting. The board must review all reports, including those submitted after the deadline.

Subd. 7. **Failure to report.** Any person, institution, insurer, or organization that fails to report as required under subdivisions 2 to 6 is subject to civil penalties for failing to report as required by law.

Sec. 21. **[148G.16] IMMUNITY.**

Subdivision 1. **Reporting.** Any person, health care facility, business, or organization is immune from civil liability and criminal prosecution for submitting in good faith a report to the board under section 148G.15 or for otherwise reporting in good faith to the board violations or alleged violations of this chapter. All such reports are investigative data as defined in chapter 13.

Subd. 2. **Investigation.** (a) Members of the board and persons employed by the board or engaged in the investigation of violations and in the preparation and management of charges of violations of this chapter on behalf of the board, or persons participating in the investigation or testifying regarding charges of violations, are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

(b) Members of the board and persons employed by the board or engaged in maintaining records and making reports regarding adverse health care events are immune from civil liability and criminal prosecution for any actions, transactions, or publications in the execution of, or relating to, their duties under this chapter.

Sec. 22. **[148G.17] CERTIFIED MIDWIFE COOPERATION.**

A certified midwife who is the subject of an investigation by or on behalf of the board must cooperate fully with the investigation. Cooperation includes responding fully and promptly to any question raised by or on behalf of the board relating to the subject of the investigation and providing copies of patient or other records in the certified midwife's possession, as reasonably requested by the board, to assist the board in its investigation and to appear at conferences and hearings scheduled by the board. The board must pay for copies requested. If the board does not have written consent from a patient permitting access to the patient's records, the certified midwife must delete any data in the record that identify the patient before providing it to the board. The board must maintain any records obtained pursuant to this section as investigative data under chapter 13. The certified midwife must not be excused from giving testimony or producing any documents, books, records, or correspondence on the grounds of self-incrimination, but the testimony or evidence must not be used against the certified midwife in any criminal case.

Sec. 23. **[148G.18] DISCIPLINARY RECORD ON JUDICIAL REVIEW.**

Upon judicial review of any board disciplinary action taken under this chapter, the reviewing court must seal the administrative record, except for the board's final decision, and must not make the administrative record available to the public.

Sec. 24. **[148G.19] EXEMPTIONS.**

The provisions of this chapter do not prohibit:

(1) the furnishing of certified midwifery assistance in an emergency;

(2) the practice of certified midwifery by any legally qualified certified midwife of another state who is employed by the United States government or any bureau, division, or agency thereof while in the discharge of official duties;

(3) the practice of any profession or occupation licensed by the state, other than certified midwifery, by any person licensed to practice the profession or occupation, or the performance by a person of any acts properly coming within the scope of the profession, occupation, or license;

(4) the practice of traditional midwifery as specified under section 147D.03;

(5) certified midwifery practice by a student practicing under the supervision of an instructor while the student is enrolled in an approved certified midwifery education program; or

(6) certified midwifery practice by a certified midwife licensed in another state, territory, or jurisdiction who is in Minnesota temporarily:

(i) providing continuing or in-service education;

(ii) serving as a guest lecturer;

(iii) presenting at a conference; or

(iv) teaching didactic content via distance education to a student located in Minnesota who is enrolled in a formal, structured course of study, such as a course leading to a higher degree in midwifery.

Sec. 25. **[148G.20] VIOLATIONS; PENALTY.**

Subdivision 1. **Violations described.** It is unlawful for any person, corporation, firm, or association to:

(1) sell or fraudulently obtain or furnish any certified midwifery diploma, license, or record, or aid or abet therein;

(2) practice certified midwifery under cover of any diploma, permit, license, certified midwife credential, or record illegally or fraudulently obtained or signed or issued unlawfully or under fraudulent representation;

(3) practice certified midwifery unless the person is licensed to do so under this chapter;

(4) use the professional title certified midwife or licensed certified midwife unless licensed to practice certified midwifery under this chapter;

(5) use any abbreviation or other designation tending to imply licensure as a certified midwife unless licensed to practice certified midwifery under this chapter;

(6) practice certified midwifery in a manner prohibited by the board in any limitation of a license issued under this chapter;

(7) practice certified midwifery during the time a license issued under this chapter is suspended or revoked;

(8) knowingly employ persons in the practice of certified midwifery who have not been issued a current license to practice as a certified midwife in this state; or

(9) conduct a certified midwifery program for the education of persons to become certified midwives unless the program has been approved by the board.

Subd. 2. **Penalty.** Any person, corporation, or association violating any provision of subdivision 1 is guilty of a gross misdemeanor and must be punished according to law.

Subd. 3. **Penalty; certified midwives.** In addition to subdivision 2, a person who practices certified midwifery without a current license and certification or recertification, or without current certification or recertification on file with the board, is subject to the applicable penalties in section 148G.11.

Sec. 26. **[148G.21] UNAUTHORIZED PRACTICE OF MIDWIFERY.**

The practice of certified midwifery by any person who is not licensed to practice certified midwifery under this chapter, whose license has been suspended or revoked, or whose national certification credential has expired, is inimical to the public health and welfare and constitutes a public nuisance. Upon a complaint being made by the board or any prosecuting officer, and upon a proper showing of the facts, the district court of the county where such practice occurred may enjoin such acts and practice. The injunction proceeding is in addition to, and not in lieu of, all other penalties and remedies provided by law.

Sec. 27. Minnesota Statutes 2024, section 151.01, subdivision 23, is amended to read:

Subd. 23. **Practitioner.** "Practitioner" means a licensed doctor of medicine, licensed doctor of osteopathic medicine duly licensed to practice medicine, licensed doctor of dentistry, licensed doctor of optometry, licensed podiatrist, licensed veterinarian, licensed advanced practice registered nurse, licensed certified midwife effective July 1, 2026, or licensed physician assistant. For purposes of sections 151.15, subdivision 4; 151.211, subdivision 3; 151.252, subdivision 3; 151.37, subdivision 2, paragraph (b); and 151.461, "practitioner" also means a dental therapist authorized to dispense and administer under chapter 150A. For purposes of sections 151.252, subdivision 3, and 151.461, "practitioner" also means a pharmacist authorized to prescribe self-administered hormonal contraceptives, nicotine replacement medications, or opiate antagonists under section 151.37, subdivision 14, 15, or 16, or authorized to prescribe drugs to prevent the acquisition of human immunodeficiency virus (HIV) under section 151.37, subdivision 17.

Sec. 28. Minnesota Statutes 2024, section 151.555, subdivision 6, is amended to read:

Subd. 6. **Standards and procedures for accepting donations of drugs and supplies and purchasing drugs from licensed wholesalers.** (a) Notwithstanding any other law or rule, a donor may donate drugs or medical supplies to the central repository or a local repository if the drug or supply meets the requirements of this section as determined by a pharmacist or practitioner who is employed by or under contract with the central repository or a local repository.

(b) A drug is eligible for donation under the medication repository program if the following requirements are met:

(1) the drug's expiration date is at least six months after the date the drug was donated. If a donated drug bears an expiration date that is less than six months from the donation date, the drug may be accepted and distributed if the drug is in high demand and can be dispensed for use by a patient before the drug's expiration date;

(2) the drug is in its original, sealed, unopened, tamper-evident packaging that includes the expiration date. Single-unit-dose drugs may be accepted if the single-unit-dose packaging is unopened;

(3) the drug or the packaging does not have any physical signs of tampering, misbranding, deterioration, compromised integrity, or adulteration;

(4) the drug does not require storage temperatures other than normal room temperature as specified by the manufacturer or United States Pharmacopoeia, unless the drug is being donated directly by its manufacturer, a wholesale drug distributor, or a pharmacy located in Minnesota; and

(5) the drug is not a controlled substance.

(c) A medical supply is eligible for donation under the medication repository program if the following requirements are met:

(1) the supply has no physical signs of tampering, misbranding, or alteration and there is no reason to believe it has been adulterated, tampered with, or misbranded;

(2) the supply is in its original, unopened, sealed packaging; and

(3) if the supply bears an expiration date, the date is at least six months later than the date the supply was donated. If the donated supply bears an expiration date that is less than six months from the date the supply was donated, the supply may be accepted and distributed if the supply is in high demand and can be dispensed for use by a patient before the supply's expiration date.

(d) The board shall develop the medication repository donor form and make it available on the board's website. Prior to the first donation from a new donor, a central repository or local repository shall verify and record the following information on the donor form:

(1) the donor's name, address, phone number, and license number, if applicable;

(2) that the donor will only make donations in accordance with the program;

(3) to the best of the donor's knowledge, only drugs or supplies that have been properly stored under appropriate temperature and humidity conditions will be donated; and

(4) to the best of the donor's knowledge, only drugs or supplies that have never been opened, used, tampered with, adulterated, or misbranded will be donated.

(e) Notwithstanding any other law or rule, a central repository or a local repository may receive donated drugs from donors. Donated drugs and supplies may be shipped or delivered to the premises of the central repository or a local repository, and shall be inspected by a pharmacist or an authorized practitioner who is employed by or under contract with the repository and who has been designated by the repository prior to dispensing. A drop box must not be used to deliver or accept donations.

(f) The central repository and local repository shall maintain a written or electronic inventory of all drugs and supplies donated to the repository upon acceptance of each drug or supply. For each drug, the inventory must include the drug's name, strength, quantity, manufacturer, expiration date, and the date the drug was donated. For each medical supply, the inventory must include a description of the supply, its manufacturer, the date the supply was donated, and, if applicable, the supply's brand name and expiration date. The board may waive the requirement under this paragraph if an entity is under common ownership or control with a central repository or local repository and either the entity or the repository maintains an inventory containing all the information required under this paragraph.

(g) The central repository may purchase a drug from a wholesaler licensed by the board to fill prescriptions for eligible patients when the repository does not have a sufficient supply of donated drugs to fill the prescription. The central repository may use any purchased drugs remaining after filling the prescriptions for which the drugs were initially purchased to fill other prescriptions. Whenever possible, the repository must use donated drugs to fill prescriptions.

Sec. 29. Minnesota Statutes 2024, section 151.555, subdivision 10, is amended to read:

Subd. 10. **Distribution of donated drugs and supplies.** (a) The central repository and local repositories may distribute drugs and supplies donated under the medication repository program to other participating repositories for use pursuant to this program.

(b) A local repository that elects not to dispense donated drugs or supplies that are suitable for donation and dispensing must transfer ~~all~~ those donated drugs and supplies to the central repository. A copy of the donor form that was completed by the original donor under subdivision 6 must be provided to the central repository at the time of transfer. A local repository must dispose of drugs and supplies in its possession that are not suitable for donation or dispensing pursuant to subdivision 7.

Sec. 30. Minnesota Statutes 2024, section 152.12, subdivision 1, is amended to read:

Subdivision 1. **Prescribing, dispensing, administering controlled substances in Schedules II through V.** A licensed doctor of medicine, a doctor of osteopathic medicine, duly licensed to practice medicine, a doctor of dental surgery, a doctor of dental medicine, a licensed doctor of podiatry, a licensed advanced practice registered nurse, a licensed certified midwife effective July 1, 2026, a licensed physician assistant, or a licensed doctor of optometry limited to Schedules IV and V, and in the course of professional practice only, may prescribe, administer, and dispense a controlled substance included in Schedules II through V of section 152.02, may cause the same to be administered by a nurse, an intern or an assistant under the direction and supervision of the doctor, and may cause a person who is an appropriately certified and licensed health care professional to prescribe and administer the same within the expressed legal scope of the person's practice as defined in Minnesota Statutes.

Sec. 31. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

Subd. 28c. **Certified midwifery practice services.** Effective January 1, 2026, or upon federal approval, whichever is later, medical assistance covers services performed by a licensed certified midwife if:

(1) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the facility payment;

(2) the service is otherwise covered under this chapter as a physician service; and

(3) the service is within the scope of practice of the certified midwife's license as defined under chapter 148G.

ARTICLE 4
PHARMACY BENEFITS

Section 1. Minnesota Statutes 2024, section 256B.0625, subdivision 13c, is amended to read:

Subd. 13c. **Formulary Committee.** The commissioner, after receiving recommendations from professional medical associations and professional pharmacy associations, and consumer groups shall designate a Formulary Committee to carry out duties as described in subdivisions 13 to 13g. The Formulary Committee shall be comprised of at least five licensed physicians actively engaged in the practice of medicine in Minnesota, one of whom is an actively practicing psychiatrist, one of whom specializes in the diagnosis and treatment of rare diseases, one of whom specializes in pediatrics, and one of whom actively treats persons with disabilities; at least three licensed pharmacists actively engaged in the practice of pharmacy in Minnesota, one of whom practices outside the metropolitan counties listed in section 473.121, subdivision 4, one of whom practices in the metropolitan counties listed in section 473.121, subdivision 4, and one of whom is a practicing hospital pharmacist; at least two consumer representatives, all of whom must have a personal or professional connection to medical assistance; and one

representative designated by the Minnesota Rare Disease Advisory Council established under section 256.4835; the remainder to be made up of health care professionals who are licensed in their field and have recognized knowledge in the clinically appropriate prescribing, dispensing, and monitoring of covered outpatient drugs. Members of the Formulary Committee shall not be employed by the Department of Human Services or have a personal interest in a pharmaceutical company, pharmacy benefits manager, health plan company, or their affiliate organizations, but the committee shall be staffed by an employee of the department who shall serve as an ex officio, nonvoting member of the committee. For the purposes of this subdivision, "personal interest" means that a person owns at least five percent of the voting interest or equity interest in the entity, the equity interest owned by a person represents at least five percent of that person's net worth, or more than five percent of a person's gross income for the preceding year was derived from the entity. A committee member must notify the committee of any potential conflict of interest and recuse themselves from any communications, discussion, or vote on any matter where a conflict of interest exists. A conflict of interest alone, without a personal interest, does not preclude an applicant from serving as a member of the Formulary Committee. Members may be removed from the committee for cause after a recommendation for removal by a majority of the committee membership. For the purposes of this subdivision, "cause" does not include offering a differing or dissenting clinical opinion on a drug or drug class. The department's medical director shall also serve as an ex officio, nonvoting member for the committee. Committee members shall serve three-year terms and may be reappointed twice by the commissioner. The committee members shall vote on a chair and vice chair from among their membership. The chair shall preside over all committee meetings, and the vice chair shall preside over the meetings if the chair is not present. The Formulary Committee shall meet at least three times per year. The commissioner may require more frequent Formulary Committee meetings as needed. An honorarium of $100 per meeting and reimbursement for mileage shall be paid to each committee member in attendance. The Formulary Committee expires June 30, ~~2027~~ 2029. The Formulary Committee is subject to the Open Meeting Law under chapter 13D. For purposes of establishing a quorum to transact business, vacant committee member positions do not count in the calculation as long as at least 60 percent of the committee member positions are filled.

Sec. 2. Minnesota Statutes 2024, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the ingredient costs of the drugs plus the professional dispensing fee; or the usual and customary price charged to the public. The usual and customary price means the lowest price charged by the provider to a patient who pays for the prescription by cash, check, or charge account and includes prices the pharmacy charges to a patient enrolled in a prescription savings club or prescription discount club administered by the pharmacy or pharmacy chain, unless the prescription savings club or prescription discount club is one in which an individual pays a recurring monthly access fee for unlimited access to a defined list of drugs for which the pharmacy does not bill the member or a payer on a per-standard-transaction basis. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any third-party provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The professional dispensing fee shall be $11.55 for prescriptions filled with legend drugs meeting the definition of "covered outpatient drugs" according to United States Code, title 42, section 1396r-8(k)(2). The dispensing fee for intravenous solutions that must be compounded by the pharmacist shall be $11.55 per claim. The professional dispensing fee for prescriptions filled with over-the-counter drugs meeting the definition of covered outpatient drugs shall be $11.55 for dispensed quantities equal to or greater than the number of units contained in the manufacturer's original package. The professional dispensing fee shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The pharmacy dispensing fee for prescribed over-the-counter drugs not meeting the definition of covered outpatient drugs shall be $3.65 for quantities equal to or greater than the number of units contained in the manufacturer's original package and shall be prorated based on the percentage of the package dispensed when the pharmacy dispenses a quantity less than the number of units contained in the manufacturer's original package. The ingredient cost for a drug is the lowest of the National Average Drug Acquisition Cost (NADAC) ~~shall be used to determine the ingredient cost of a drug~~; the Minnesota actual acquisition cost (MNAAC), as defined in paragraph

(i); or the maximum allowable cost. For drugs for which a NADAC, MNAAC, or maximum allowable cost is not reported, the commissioner shall estimate the ingredient cost at the wholesale acquisition cost minus two percent. The ingredient cost of a drug for a provider participating in the federal 340B Drug Pricing Program shall be ~~either~~ the 340B Drug Pricing Program ceiling price established by the Health Resources and Services Administration ~~or~~, the NADAC, the MNAAC, or the maximum allowable cost, whichever is ~~lower~~ lowest. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a ~~multisource~~ drug may be set by the commissioner and it shall be comparable to the actual acquisition cost of the drug product and no higher than the NADAC of the generic product. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

(c) A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(d) If a pharmacy dispenses a multisource drug, the ingredient cost shall be the lesser of the NADAC of the generic product, the MNAAC of the generic product, or the maximum allowable cost of the generic product established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2. If prior authorization is granted, the ingredient cost shall be the lesser of the NADAC of the brand name product, the MNAAC of the brand name product, or the maximum allowable cost of the brand name product. A generic product includes a generic drug, an authorized generic drug, and a biosimilar biological product as defined in Code of Federal Regulations, title 42, section 423.4. A brand name product includes a brand name drug, a brand name biological product, and an unbranded biological product as defined in Code of Federal Regulations, title 42, section 423.4.

(e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the ~~specialty pharmacy rate~~ MNAAC, or the maximum allowable cost set by the commissioner. If average sales price ~~is~~, MNAAC, and the maximum allowable cost are unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider~~,~~ or the wholesale acquisition cost~~, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner~~. The commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 28.6 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

~~(f) The commissioner may establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high cost therapies, and therapies that require complex care. The commissioner shall consult with the Formulary Committee to develop a list of specialty pharmacy products subject to maximum allowable cost reimbursement. In consulting with the Formulary Committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the maximum allowable cost to prevent access to care issues.~~

~~(g)~~ (f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

~~(h)~~ (g) The commissioner shall contract with a vendor to conduct a cost of dispensing survey for all pharmacies that are physically located in the state of Minnesota that dispense outpatient drugs under medical assistance. The commissioner shall ensure that the vendor has prior experience in conducting cost of dispensing surveys. Each pharmacy enrolled with the department to dispense outpatient prescription drugs to fee-for-service members must respond to the cost of dispensing survey. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The commissioner shall require the vendor to measure a single statewide cost of dispensing for specialty prescription drugs and a single statewide cost of dispensing for nonspecialty prescription drugs for all responding pharmacies to measure the mean, mean weighted by total prescription volume, mean weighted by medical assistance prescription volume, median, median weighted by total prescription volume, and median weighted by total medical assistance prescription volume. The commissioner shall post a copy of the final cost of dispensing survey report on the department's website. The initial survey must be completed no later than January 1, 2021, and repeated every three years. The commissioner shall provide a summary of the results of each cost of dispensing survey and provide recommendations for any changes to the dispensing fee to the chairs and ranking minority members of the legislative committees with jurisdiction over medical assistance pharmacy reimbursement. Notwithstanding section 256.01, subdivision 42, this paragraph does not expire.

~~(i)~~ (h) The commissioner shall increase the ingredient cost reimbursement calculated in paragraphs (a) and ~~(f)~~ (e) by ~~1.8 percent~~ the amount of the wholesale drug distributor tax for prescription and nonprescription drugs subject to the wholesale drug distributor tax under section 295.52.

(i) The commissioner shall contract with a vendor to create the MNAAC through a periodic survey of enrolled pharmacy providers. Each pharmacy enrolled with the department to dispense outpatient prescription drugs must respond to the periodic surveys. The commissioner may sanction a pharmacy under section 256B.064 for failure to respond. The current MNAAC rates must be publicly available on the department's or vendor's website. The commissioner must require that the MNAAC is measured and calculated at least quarterly, but the MNAAC can be measured and calculated more frequently. The commissioner must ensure that the vendor has an appeal process available to providers for the time between the measurement and calculation of the periodically updated MNAAC rates if price fluctuations result in a MNAAC that is lower than what enrolled providers can purchase a drug for. Establishment of the MNAAC and survey reporting requirements are not subject to the requirements of the Administrative Procedure Act. Data provided by pharmacies for the measurement and calculation of the MNAAC is nonpublic data as defined under section 13.02, subdivision 9.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 3. Minnesota Statutes 2024, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against any individual or entity that receives payments from medical assistance or provides goods or services for which payment is made from medical assistance for any of the following: (1) fraud, theft, or abuse in connection with the provision of goods and services to recipients of public assistance for which payment is made from medical assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the individual or entity is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; and (8) any reason for which an individual or entity could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. For the purposes of this section, goods or services for which payment is made from medical assistance includes but is not limited to care and services identified in section 256B.0625 or provided pursuant to any federally approved waiver.

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

(c) 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).

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 4. Minnesota Statutes 2024, section 256B.69, subdivision 6d, is amended to read:

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

(b) The contracts must maintain incentives for the managed care plan to manage drug costs and utilization and may require that the managed care plans maintain an open drug formulary. In order to manage drug costs and utilization, the contracts may authorize the managed care plans to use preferred drug lists and prior authorization. The contracts must require that the managed care plans enter into contracts with the state pharmacy benefit manager under section 256B.696 to administer the pharmacy benefit.

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

Sec. 5. **[256B.696] PRESCRIPTION DRUGS; STATE PHARMACY BENEFIT MANAGER.**

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

(b) "Managed care enrollees" means medical assistance and MinnesotaCare enrollees receiving coverage from managed care plans.

(c) "Managed care plans" means health plans and county-based purchasing organizations providing coverage to medical assistance and MinnesotaCare enrollees under the managed care delivery system.

(d) "State pharmacy benefit manager" means the pharmacy benefit manager that is a prepaid ambulatory plan as defined in Code of Federal Regulations, title 42, section 438.2, selected pursuant to the procurement process in subdivision 2.

Subd. 2. **Procurement process.** (a) The commissioner must, through a competitive procurement process in compliance with paragraph (b), select a single pharmacy benefit manager to comply with the requirements set forth in subdivision 3.

(b) The commissioner must, when selecting the single pharmacy benefit manager, do the following:

(1) accept applications for entities seeking to become the single pharmacy benefit manager;

(2) establish eligibility criteria an entity must meet in order to become the single pharmacy benefit manager; and

(3) enter into a master contract with a single pharmacy benefit manager.

(c) The contract required under paragraph (b), clause (3), must include a prohibition on:

(1) the single pharmacy benefit manager requiring an enrollee to obtain a drug from a pharmacy owned or otherwise affiliated with the single pharmacy benefit manager; and

(2) paying or reimbursing a pharmacy or pharmacist for the ingredient drug product component of pharmacist services, including a prescription drug, less than the lesser of the national average drug acquisition cost; the Minnesota actual acquisition cost (MNAAC) as defined in section 256B.0625, subdivision 13e, paragraph (j); or the maximum allowable cost as defined in section 62W.08, of that pharmacy service or prescription drug, or, if the national average drug acquisition cost is unavailable, the wholesale acquisition cost minus two percent at the time the drug is administered or dispensed, plus a professional dispensing fee equal to the amount of the dispensing fee if it were determined pursuant to section 256B.0625, subdivision 13e.

(d) Applicants for the single pharmacy benefit manager must disclose to the commissioner the following during the procurement process:

(1) any activity, policy, practice, contract, or arrangement of the single pharmacy benefit manager that may directly or indirectly present any conflict of interest with the pharmacy benefit manager's relationship with or obligation to the Department of Human Services, a health plan company, or county-based purchasing organization;

(2) all common ownership, members of a board of directors, managers, or other control of the pharmacy benefit manager or any of the pharmacy benefit manager's affiliated companies with:

(i) a health plan company administering the medical assistance or MinnesotaCare benefits or an affiliate of the health plan company;

(ii) a county-based purchasing organization;

(iii) an entity that contracts on behalf of a pharmacy or any pharmacy services administration organization and its affiliates;

(iv) a drug wholesaler or distributor and its affiliates;

(v) a third-party payer and its affiliates; or

(vi) a pharmacy and its affiliates that are enrolled to provide medical assistance or MinnesotaCare;

(3) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state with which the pharmacy benefit manager shares common ownership, management, or control, or that are owned, managed, or controlled by any of the pharmacy benefit manager's affiliated companies;

(4) any direct or indirect fees, charges, or any kind of assessments imposed by the pharmacy benefit manager on pharmacies licensed in this state; and

(5) any financial terms and arrangements between the pharmacy benefit manager and a prescription drug manufacturer or labeler, including formulary management, drug substitution programs, educational support claims processing, or data sales fees.

Subd. 3. **Drug coverage.** (a) The commissioner may require the pharmacy benefit manager to modify utilization review limitations, requirements, and strategies imposed by managed care plans on prescription drug coverage.

(b) The state pharmacy benefit manager is responsible for processing all point of sale outpatient pharmacy claims under the managed care delivery system. Managed care plans must use the state pharmacy benefit manager pursuant to the terms of the master contract required under subdivision 2, paragraph (b), clause (3). The pharmacy benefit manager selected is the exclusive pharmacy benefit manager used by health plan companies and county-based purchasing organizations when providing coverage to enrollees. The commissioner may require the managed care plans and pharmacy benefit manager to directly exchange data and files for members enrolled with managed care plans.

(c) All payment arrangements between the Department of Human Services, managed care plans, and the state pharmacy benefit manager must comply with state and federal statutes, regulations adopted by the Centers for Medicare and Medicaid Services, and any other agreement between the department and the Centers for Medicare and Medicaid Services. The commissioner may change a payment arrangement to comply with this paragraph.

(d) The commissioner must administer and oversee this section to:

(1) ensure proper administration of prescription drug benefits for managed care enrollees; and

(2) increase the transparency of prescription drug prices and other information for the benefit of pharmacies.

Subd. 4. **Prescription drug disclosures.** (a) The state pharmacy benefit manager must, on request from the commissioner, disclose to the commissioner all sources of payment the state pharmacy benefit manager receives for prescribed drugs, including any financial benefits, drug rebates, discounts, credits, clawbacks, fees, grants, chargebacks, reimbursements, or other payments related to services provided for a managed care plan.

(b) Each managed care plan must disclose to the commissioner, in the format specified by the commissioner, the entity's administrative costs associated with providing pharmacy services under the managed care delivery system.

(c) The state pharmacy benefit manager must provide a written quarterly report to the commissioner containing the following information from the immediately preceding quarter:

(1) the prices the state pharmacy benefit manager negotiated for prescribed drugs under the managed care delivery system. The price must include any rebates the state pharmacy benefit manager received from the drug manufacturer;

(2) any rebate amounts the state pharmacy benefit manager passed on to individual pharmacies;

(3) any changes to the information previously disclosed under subdivision 2, paragraph (d); and

(4) any other information required by the commissioner, including unredacted copies of contracts between the pharmacy benefit manager and enrolled pharmacies.

(d) The commissioner may request and collect additional information and clinical data from the state pharmacy benefit manager.

(e) At the time of contract execution, renewal, or modification, the commissioner must modify the reporting requirements under its managed care contracts as necessary to meet the requirements of this subdivision.

Subd. 5. **Program authority.** (a) To accomplish the requirements of subdivision 3, the commissioner, in consultation with the Formulary Committee established under section 256B.0625, subdivision 13c, has the authority to:

(1) adopt or develop a preferred drug list for managed care plans;

(2) at the commissioner's discretion, engage in price negotiations with prescription drug manufacturers, wholesalers, or group purchasing organizations in place of the state pharmacy benefit manager to obtain price discounts and rebates for prescription drugs for managed care enrollees; and

(3) develop and manage a drug formulary for managed care plans.

(b) The commissioner may contract with one or more entities to perform any of the functions described in paragraph (a).

Subd. 6. **Pharmacies.** The commissioner may review contracts between the state pharmacy benefit manager and pharmacies for compliance with this section and the master contract required under subdivision 2, paragraph (b), clause (3). The commissioner may amend any term or condition of a contract that does not comply with this section or the master contract.

Subd. 7. **Federal approval.** The commissioner must seek any necessary federal approvals to implement this section.

EFFECTIVE DATE. Subdivisions 1 to 6 are effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained. Subdivision 7 is effective the day following final enactment.

Sec. 6. **DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; DIRECTED PHARMACY DISPENSING PAYMENTS.**

(a) For plan year 2026, the commissioner shall provide a directed pharmacy dispensing payment of $1.84 per filled prescription under the medical assistance program to eligible outpatient retail pharmacies in Minnesota to improve and maintain access to pharmaceutical services in rural and underserved areas of the state. Managed care and county-based purchasing plans delivering services under Minnesota Statutes, section 256B.69 or 256B.692, and any pharmacy benefit managers under contract with these entities, must pay the directed pharmacy dispensing payment to eligible outpatient retail pharmacies for drugs dispensed to medical assistance enrollees. The directed pharmacy dispensing payment is in addition to, and must not supplant or reduce, any other dispensing fee paid by these entities to the pharmacy. Entities paying the directed pharmacy dispensing payment must not reduce other payments to the pharmacy as a result of payment of the directed pharmacy dispensing payment.

(b) For purposes of this section, "eligible outpatient retail pharmacy" means an outpatient retail pharmacy licensed under chapter 151 that is not owned, either directly or indirectly or through an affiliate or subsidiary, by a pharmacy benefit manager licensed under chapter 62W or a health carrier, as defined in Minnesota Statutes, section 62A.011, subdivision 2, and that:

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

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

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

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

(e) Managed care and county-based purchasing plans, and any pharmacy benefit managers under contract with these entities, shall pay the directed pharmacy dispensing payment to eligible outpatient retail pharmacies. The commissioner shall monitor the effect of this requirement on access to pharmaceutical services in rural and underserved areas of the state. If, for any contract year, federal approval is not received for this section, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect removal of this section. Contracts between managed care plans and county-based purchasing plans, and any pharmacy benefit managers under contract with these entities, and providers to whom this section applies, must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this section. This section expires if federal approval is not received for this section at any time.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

ARTICLE 5
HEALTH CARE FINANCE

Section 1. Minnesota Statutes 2024, section 62A.673, subdivision 2, is amended to read:

Subd. 2. **Definitions.** (a) For purposes of this section, the terms defined in this subdivision have the meanings given.

(b) "Distant site" means a site at which a health care provider is located while providing health care services or consultations by means of telehealth.

(c) "Health care provider" means a health care professional who is licensed or registered by the state to perform health care services within the provider's scope of practice and in accordance with state law. A health care provider includes a mental health professional under section 245I.04, subdivision 2; a mental health practitioner under section 245I.04, subdivision 4; a clinical trainee under section 245I.04, subdivision 6; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; and a recovery peer under section 245G.11, subdivision 8.

(d) "Health carrier" has the meaning given in section 62A.011, subdivision 2.

(e) "Health plan" has the meaning given in section 62A.011, subdivision 3. Health plan includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred, and are designed to pay benefits directly to the policy holder.

(f) "Originating site" means a site at which a patient is located at the time health care services are provided to the patient by means of telehealth. For purposes of store-and-forward technology, the originating site also means the location at which a health care provider transfers or transmits information to the distant site.

(g) "Store-and-forward technology" means the asynchronous electronic transfer or transmission of a patient's medical information or data from an originating site to a distant site for the purposes of diagnostic and therapeutic assistance in the care of a patient.

(h) "Telehealth" means the delivery of health care services or consultations through the use of real time two-way interactive audio and visual communications to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes the application of secure video conferencing, store-and-forward technology, and synchronous interactions between a patient located at an originating site and a health care provider located at a distant site. Until July 1, ~~2025~~ 2028, telehealth also includes audio-only communication between a health care provider and a patient ~~in accordance with subdivision 6, paragraph (b)~~ if the communication is a scheduled appointment and the standard of care for that particular service can be met through the use of audio-only communication or if, for substance use disorder treatment services and mental health care services delivered through telehealth by means of audio-only communication, the communication was initiated by the enrollee while in an emergency or crisis situation and a scheduled appointment was not possible due to the need of an immediate response. Telehealth does not include communication between health care providers that consists solely of a telephone conversation, email, or facsimile transmission. Telehealth does not include communication between a health care provider and a patient that consists solely of an email or facsimile transmission. Telehealth does not include telemonitoring services as defined in paragraph (i).

(i) "Telemonitoring services" means the remote monitoring of clinical data related to the enrollee's vital signs or biometric data by a monitoring device or equipment that transmits the data electronically to a health care provider for analysis. Telemonitoring is intended to collect an enrollee's health-related data for the purpose of assisting a health care provider in assessing and monitoring the enrollee's medical condition or status.

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

Sec. 2. Minnesota Statutes 2024, section 174.30, subdivision 3, is amended to read:

Subd. 3. **Other standards; wheelchair securement; protected transport.** (a) A special transportation service that transports individuals occupying wheelchairs is subject to the provisions of sections 299A.11 to 299A.17 concerning wheelchair securement devices. The commissioners of transportation and public safety shall cooperate in the enforcement of this section and sections 299A.11 to 299A.17 so that a single inspection is sufficient to ascertain compliance with sections 299A.11 to 299A.17 and with the standards adopted under this section. Representatives of the Department of Transportation may inspect wheelchair securement devices in vehicles operated by special transportation service providers to determine compliance with sections 299A.11 to 299A.17 and to issue certificates under section 299A.14, subdivision 4.

(b) In place of a certificate issued under section 299A.14, the commissioner may issue a decal under subdivision 4 for a vehicle equipped with a wheelchair securement device if the device complies with sections 299A.11 to 299A.17 and the decal displays the information in section 299A.14, subdivision 4.

(c) For vehicles designated as protected transport under section 256B.0625, subdivision 17, paragraph ~~(l)~~ (n), the commissioner of transportation, during the commissioner's inspection, shall check to ensure the safety provisions contained in that paragraph are in working order.

Sec. 3. Minnesota Statutes 2024, section 256.9657, subdivision 2, is amended to read:

Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the ~~medical assistance account~~ health care access fund a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

Sec. 4. Minnesota Statutes 2024, section 256.9657, is amended by adding a subdivision to read:

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

(1) "eligible hospital" means a hospital:

(i) licensed under section 144.50;

(ii) located in Minnesota; and

(iii) with a Medicare cost report filed and showing in the Healthcare Cost Report Information System (HCRIS);

(2) "net outpatient revenue" means the value to reflect total outpatient revenue less Medicare revenue as calculated from Worksheet G of the hospital's Medicare cost report; and

(3) "total patient days" means the value to reflect total hospital inpatient days as reported on Worksheet S-3 of the hospital's Medicare cost report.

(b) Subject to paragraphs (k) to (n), each eligible hospital must pay assessments to the hospital directed payment program account, with an aggregate annual assessment amount equal to the sum of the following:

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

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

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

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

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

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

(d) The commissioner may, after consultation with the Minnesota Hospital Association, modify the rates of assessment in paragraph (b) as necessary to comply with federal law, obtain or maintain a waiver under Code of Federal Regulations, title 42, section 433.72, or otherwise maximize under this section federal financial participation for medical assistance.

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

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

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

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

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

(j) If the commissioner determines that a hospital has underpaid or overpaid an assessment, the commissioner must notify the hospital of the unpaid assessment or of any refund due.

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

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

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

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

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

(1) Hennepin Healthcare, with a discount of 25 percent off the inpatient portion of the assessment rate;

(2) Mayo Rochester, with a discount of ten percent off the inpatient portion of the assessment rate;

(3) Gillette Children's Hospital, with a discount of 90 percent off the inpatient portion of the assessment rate;

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

(5) a discount off the inpatient portion of the assessment rate, as is necessary, in order to ensure that no single hospital is responsible for greater than 12 percent of the total assessment annually collected statewide.

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

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

(2) Gillette Children's Hospital, with a discount of 90 percent off the outpatient portion of the assessment rate;

(3) Hennepin Healthcare, with a discount of 60 percent off the outpatient portion of the assessment rate;

(4) Mayo Rochester, with a discount of 20 percent off the outpatient portion of the assessment rate; and

(5) each hospital not included in another discount category, and with greater than $200,000,000 in total medical assistance inpatient and outpatient revenue in fee-for-service and managed care, as reported in the state fiscal year 2022 Medicare cost report, with a discount of ten percent off the outpatient portion of the assessment rate.

(o) The commissioner must fully exempt the following from the assessment in this section:

(1) federal Indian Health Service facilities;

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

(3) federal Veterans Administration Medical Centers; and

(4) long-term acute care hospitals.

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

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

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) the waiver for the assessment required under this section; and

(2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 5. Minnesota Statutes 2024, section 256.969, subdivision 2f, is amended to read:

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

(b) For hospitals eligible to receive payment under section 256B.1973 or 256B.1974 and meeting the criteria in subdivision 9, paragraph (d), the commissioner shall reduce the amount calculated under subdivision 9, paragraph (d), by one percent and compute an alternate inpatient payment rate. The alternate payment rate shall be structured to target a total aggregate reimbursement amount equal to what the hospital would have received for providing fee-for-service inpatient services under this section to patients enrolled in medical assistance had the hospital received 99 percent of the entire amount calculated under subdivision 9, paragraph (d). Hospitals that do not meet federal requirements for Medicaid disproportionate share hospitals are not eligible for this alternate payment.

EFFECTIVE DATE. (a) Paragraph (b) of this section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) this section; and

(2) the amendments in this act to Minnesota Statutes, sections 256B.1973 and 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 6. Minnesota Statutes 2024, section 256B.0371, subdivision 3, is amended to read:

Subd. 3. **Contingent contract with dental administrator.** (a) The commissioner shall determine the extent to which managed care ~~and county-based purchasing~~ plans in the aggregate meet the performance benchmark specified in subdivision 1 for coverage year 2024. If managed care ~~and county-based purchasing~~ plans in the aggregate fail to meet the performance benchmark, the commissioner, after issuing a request for information followed by a request for proposals, shall contract with a dental administrator to administer dental services beginning January 1, ~~2026~~ 2028, for ~~all~~ recipients of medical assistance and MinnesotaCare~~, including persons~~ who are served under fee-for-service and persons receiving services through managed care ~~and county-based purchasing~~ plans.

(b) The dental administrator must provide administrative services, including but not limited to:

(1) provider recruitment, contracting, and assistance;

(2) recipient outreach and assistance;

(3) utilization management and reviews of medical necessity for dental services;

(4) dental claims processing;

(5) coordination of dental care with other services;

(6) management of fraud and abuse;

(7) monitoring access to dental services statewide;

(8) performance measurement;

(9) quality improvement and evaluation; ~~and~~

(10) management of third-party liability requirements~~.~~; and

(11) establishment of grievance and appeals processes for providers and enrollees that the commissioner can monitor.

(c) Dental administrator payments to contracted dental providers must be ~~at the~~ based on rates ~~established under sections 256B.76 and 256L.11~~ recommended by the dental access working group. If the recommended rates are not established in law prior to July 1, 2027, then dental administrator payments to contracted dental providers must be at the rates established under sections 256B.76 and 256L.11.

(d) Recipients must be given a choice of dental provider, including any provider who agrees to provider participation requirements and payment rates established by the commissioner and dental administrator. The dental administrator must comply with the network adequacy and geographic access requirements that apply to managed care ~~and county-based purchasing~~ plans for dental services under section 62K.14.

(e) The contract with the dental administrator must include ~~a provision that states that if the dental administrator fails to meet, by calendar year 2029, a performance benchmark under which at least 55 percent of children and adults who were continuously enrolled for at least 11 months in either medical assistance or MinnesotaCare received at least one dental visit during the calendar year, the contract must be terminated and the commissioner must enter into a contract with a new dental administrator as soon as practicable~~ performance benchmarks, accountability measures, and progress rewards based on the recommendations from the dental access working group.

~~(f) The commissioner shall implement this subdivision in consultation with representatives of providers who provide dental services to patients enrolled in medical assistance or MinnesotaCare, including but not limited to providers serving primarily low-income and socioeconomically complex populations, and with representatives of managed care plans and county-based purchasing plans.~~

Sec. 7. Minnesota Statutes 2024, section 256B.04, subdivision 12, is amended to read:

Subd. 12. **Limitation on services.** (a) The commissioner shall place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service. The state agency shall promulgate rules establishing maximum reimbursement rates for emergency and nonemergency transportation.

The rules shall provide:

(1) an opportunity for all recognized transportation providers to be reimbursed for nonemergency transportation consistent with the maximum rates established by the agency; and

(2) reimbursement of public and private nonprofit providers serving the population with a disability generally at reasonable maximum rates that reflect the cost of providing the service regardless of the fare that might be charged by the provider for similar services to individuals other than those receiving medical assistance or medical care under this chapter. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(b) The commissioner shall encourage providers reimbursed under this chapter to coordinate their operation with similar services that are operating in the same community. To the extent practicable, the commissioner shall encourage eligible individuals to utilize less expensive providers capable of serving their needs. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(c) For the purpose of this subdivision and section 256B.02, subdivision 8, and effective on January 1, 1981, "recognized provider of transportation services" means an operator of special transportation service as defined in section 174.29 that has been issued a current certificate of compliance with operating standards of the commissioner of transportation or, if those standards do not apply to the operator, that the agency finds is able to provide the required transportation in a safe and reliable manner. Until January 1, 1981, "recognized transportation provider" includes an operator of special transportation service that the agency finds is able to provide the required transportation in a safe and reliable manner. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(d) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner shall place limits on the types of services covered by medical assistance, the frequency with which the same or similar services may be covered by medical assistance for an individual recipient, and the amount paid for each covered service.

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

Sec. 8. Minnesota Statutes 2024, section 256B.04, subdivision 14, is amended to read:

Subd. 14. **Competitive bidding.** (a) When determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C, to provide items under the medical assistance program including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment;

(viii) electronic diagnostic, therapeutic and life-support systems; and

(ix) allergen-reducing products as described in section 256B.0625, subdivision 67, paragraph (c) or (d);

(5) nonemergency medical transportation level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursements;

(6) drugs; and

(7) quitline services as described in section 256B.0625, subdivision 68, paragraph (c).

This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(b) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, when determined to be effective, economical, and feasible, the commissioner may utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C to provide items under the medical assistance program, including but not limited to the following:

(1) eyeglasses;

(2) oxygen. The commissioner shall provide for oxygen needed in an emergency situation on a short-term basis, until the vendor can obtain the necessary supply from the contract dealer;

(3) hearing aids and supplies;

(4) durable medical equipment, including but not limited to:

(i) hospital beds;

(ii) commodes;

(iii) glide-about chairs;

(iv) patient lift apparatus;

(v) wheelchairs and accessories;

(vi) oxygen administration equipment;

(vii) respiratory therapy equipment; and

(viii) electronic diagnostic, therapeutic, and life-support systems;

(5) nonemergency medical transportation; and

(6) drugs.

~~(b)~~ (c) Rate changes and recipient cost-sharing under this chapter and chapter 256L do not affect contract payments under this subdivision unless specifically identified.

~~(c)~~ (d) The commissioner may not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for special transportation services or incontinence products and related supplies. This paragraph expires July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

(e) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, the commissioner must not utilize volume purchase through competitive bidding and negotiation under the provisions of chapter 16C for incontinence products and related supplies.

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

Sec. 9. Minnesota Statutes 2024, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telehealth services.** (a) Medical assistance covers medically necessary services and consultations delivered by a health care provider through telehealth in the same manner as if the service or consultation was delivered through in-person contact. Services or consultations delivered through telehealth shall be paid at the full allowable rate.

(b) The commissioner may establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service through telehealth. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide through telehealth;

(2) has written policies and procedures specific to services delivered through telehealth that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the service is delivered through telehealth;

(4) has established protocols addressing how and when to discontinue telehealth services; and

(5) has an established quality assurance process related to delivering services through telehealth.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service delivered through telehealth to a medical assistance enrollee. Health care service records for services delivered through telehealth must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service delivered through telehealth;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the health care provider's basis for determining that telehealth is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission used to deliver the service through telehealth and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's consultation with another physician through telehealth, the written opinion from the consulting physician providing the telehealth consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) Telehealth visits provided through audio and visual communication or accessible video-based platforms may be used to satisfy the face-to-face requirement for reimbursement under the payment methods that apply to a federally qualified health center, rural health clinic, Indian health service, 638 tribal clinic, and certified community behavioral health clinic, if the service would have otherwise qualified for payment if performed in person.

(e) For purposes of this subdivision, unless otherwise covered under this chapter:

(1) "telehealth" means the delivery of health care services or consultations using real-time two-way interactive audio and visual communication or accessible telehealth video-based platforms to provide or support health care delivery and facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care. Telehealth includes: the application of secure video conferencing consisting of a real-time, full-motion synchronized video; store-and-forward technology; and synchronous interactions, between a patient located at an originating site and a health care provider located at a distant site. Telehealth does not include communication between health care providers, or between a health care provider and a patient that consists solely of an audio-only communication, email, or facsimile transmission or as specified by law, except that between July 1, 2025, and July 1, 2028, telehealth includes communication between a health care provider and a patient that solely consists of audio-only communication;

(2) "health care provider" means a health care provider as defined under section 62A.673; a community paramedic as defined under section 144E.001, subdivision 5f; a community health worker who meets the criteria under subdivision 49, paragraph (a); a mental health certified peer specialist under section 245I.04, subdivision 10; a mental health certified family peer specialist under section 245I.04, subdivision 12; a mental health rehabilitation worker under section 245I.04, subdivision 14; a mental health behavioral aide under section 245I.04, subdivision 16; a treatment coordinator under section 245G.11, subdivision 7; an alcohol and drug counselor under section 245G.11, subdivision 5; or a recovery peer under section 245G.11, subdivision 8; and

(3) "originating site," "distant site," and "store-and-forward technology" have the meanings given in section 62A.673, subdivision 2.

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

Sec. 10. Minnesota Statutes 2024, section 256B.0625, subdivision 17, is amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(g) 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.

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

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

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

(k) Effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance, nonemergency medical transportation providers must take clients to the health care provider using the most direct route and must not exceed 30 miles for a trip to a primary care provider or 60 miles for a trip to a specialty care provider, unless the client receives authorization from the administrator.

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

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

~~(l)~~ (n) The covered modes of transportation are:

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

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

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

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

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

(6) protected transport, which includes transport provided to a client who has received a prescreening that has deemed other forms of transportation inappropriate and who requires a provider: (i) with a protected vehicle that is not an ambulance or police car and has safety locks, a video recorder, and a transparent thermoplastic partition between the passenger and the vehicle driver; and (ii) who is certified as a protected transport provider; and

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

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

~~(n)~~ (p) The commissioner shall:

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

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

(3) investigate all complaints and appeals.

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

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

(1) $0.22 per mile for client reimbursement;

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

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

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

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

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

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

(s) 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), not the type of vehicle used to provide the service.

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

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

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

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

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

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

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

Sec. 11. Minnesota Statutes 2024, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** (a) Medical assistance covers ambulance services. Providers shall bill ambulance services according to Medicare criteria. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

(b) Effective for services provided on or after July 1, 2016, medical assistance payment rates for ambulance services identified in this paragraph are increased by five percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2017, shall be increased to reflect this rate increase. The increased rate described in this paragraph applies to ambulance service providers whose base of operations as defined in section 144E.10 is located:

(1) outside the metropolitan counties listed in section 473.121, subdivision 4, and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or

(2) within a municipality with a population of less than 1,000.

(c) Effective for services provided statewide on or after January 1, 2026, medical assistance payment rates for ambulance services are increased by 13.68 percent. Capitation payments made to managed care plans and county-based purchasing plans for ambulance services provided on or after January 1, 2026, must be increased to reflect this rate increase.

~~(c)~~ (d) Effective for the first day of each calendar quarter in which the price of gasoline as posted publicly by the United States Energy Information Administration exceeds $3.00 per gallon, the commissioner shall adjust the rate paid per mile in paragraph (a) by one percent up or down for every increase or decrease of ten cents for the price of gasoline. The increase or decrease must be calculated using a base gasoline price of $3.00. The percentage increase or decrease must be calculated using the average of the most recently available price of all grades of gasoline for Minnesota as posted publicly by the United States Energy Information Administration.

~~(d)~~ (e) Managed care plans and county-based purchasing plans must provide a fuel adjustment for ambulance services rates when fuel exceeds $3 per gallon. If, for any contract year, federal approval is not received for this paragraph, the commissioner must adjust the capitation rates paid to managed care plans and county-based purchasing plans for that contract year to reflect the removal of this provision. Contracts between managed care plans and county-based purchasing plans and providers to whom this paragraph applies must allow recovery of payments from those providers if capitation rates are adjusted in accordance with this paragraph. Payment recoveries must not exceed the amount equal to any increase in rates that results from this paragraph. This paragraph expires if federal approval is not received for this paragraph at any time.

Sec. 12. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision to read:

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

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

Sec. 13. Minnesota Statutes 2024, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center (FQHC) that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. An FQHC that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, an FQHC shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. FQHCs that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), an FQHC or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those FQHCs and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For FQHCs and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not FQHCs or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring an FQHC or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, through December 31, 2020, each FQHC and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) Effective for services provided on or after January 1, 2021, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner, according to an annual election by the FQHC or rural health clinic, under the current prospective payment system described in paragraph (f) or the alternative payment methodology described in paragraph (l), or, upon federal approval, for FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act, as provided under paragraph (k).

(h) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; and

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed.

(i) Effective for services provided on or after January 1, 2015, all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid by the commissioner. the commissioner shall determine the most feasible method for paying claims from the following options:

(1) FQHCs and rural health clinics submit claims directly to the commissioner for payment, and the commissioner provides claims information for recipients enrolled in a managed care or county-based purchasing plan to the plan, on a regular basis; or

(2) FQHCs and rural health clinics submit claims for recipients enrolled in a managed care or county-based purchasing plan to the plan, and those claims are submitted by the plan to the commissioner for payment to the clinic.

(j) For clinic services provided prior to January 1, 2015, the commissioner shall calculate and pay monthly the proposed managed care supplemental payments to clinics, and clinics shall conduct a timely review of the payment calculation data in order to finalize all supplemental payments in accordance with federal law. Any issues arising from a clinic's review must be reported to the commissioner by January 1, 2017. Upon final agreement between the commissioner and a clinic on issues identified under this subdivision, and in accordance with United States Code, title 42, section 1396a(bb), no supplemental payments for managed care plan or county-based purchasing plan claims for services provided prior to January 1, 2015, shall be made after June 30, 2017. If the commissioner and clinics are unable to resolve issues under this subdivision, the parties shall submit the dispute to the arbitration process under section 14.57.

(k) The commissioner shall establish an encounter payment rate that is equivalent to the all inclusive rate (AIR) payment established by the Indian Health Service and published in the Federal Register. The encounter rate must be updated annually and must reflect the changes in the AIR established by the Indian Health Service each calendar year. FQHCs that are also urban Indian organizations under Title V of the federal Indian Health Improvement Act may elect to be paid: (1) at the encounter rate established under this paragraph; (2) under the alternative payment methodology described in paragraph (l); or (3) under the federally required prospective payment system described in paragraph (f). FQHCs that elect to be paid at the encounter rate established under this paragraph must continue to meet all state and federal requirements related to FQHCs and urban Indian organizations, and must maintain their statuses as FQHCs and urban Indian organizations.

(l) All claims for payment of clinic services provided by FQHCs and rural health clinics, that have elected to be paid under this paragraph, shall be paid by the commissioner according to the following requirements:

(1) the commissioner shall establish a single medical and single dental organization encounter rate for each FQHC and rural health clinic when applicable;

(2) each FQHC and rural health clinic is eligible for same day reimbursement of one medical and one dental organization encounter rate if eligible medical and dental visits are provided on the same day;

(3) the commissioner shall reimburse FQHCs and rural health clinics, in accordance with current applicable Medicare cost principles, their allowable costs, including direct patient care costs and patient-related support services. Nonallowable costs include, but are not limited to:

(i) general social services and administrative costs;

(ii) retail pharmacy;

(iii) patient incentives, food, housing assistance, and utility assistance;

(iv) external lab and x-ray;

(v) navigation services;

(vi) health care taxes;

(vii) advertising, public relations, and marketing;

(viii) office entertainment costs, food, alcohol, and gifts;

(ix) contributions and donations;

(x) bad debts or losses on awards or contracts;

(xi) fines, penalties, damages, or other settlements;

(xii) fundraising, investment management, and associated administrative costs;

(xiii) research and associated administrative costs;

(xiv) nonpaid workers;

(xv) lobbying;

(xvi) scholarships and student aid; and

(xvii) nonmedical assistance covered services;

(4) the commissioner shall review the list of nonallowable costs in the years between the rebasing process established in clause (5), in consultation with the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics. The commissioner shall publish the list and any updates in the Minnesota health care programs provider manual;

(5) the initial applicable base year organization encounter rates for FQHCs and rural health clinics shall be computed for services delivered on or after January 1, 2021, and:

(i) must be determined using each FQHC's and rural health clinic's Medicare cost reports from 2017 and 2018;

(ii) must be according to current applicable Medicare cost principles as applicable to FQHCs and rural health clinics without the application of productivity screens and upper payment limits or the Medicare prospective payment system FQHC aggregate mean upper payment limit;

(iii) must be subsequently rebased every two years thereafter using the Medicare cost reports that are three and four years prior to the rebasing year. Years in which organizational cost or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency shall not be used as part of a base year when the base year includes more than one year. The commissioner may use the Medicare cost reports of a year unaffected by a pandemic, disease, or other public health emergency, or previous two consecutive years, inflated to the base year as established under item (iv);

(iv) must be inflated to the base year using the inflation factor described in clause (6); and

(v) the commissioner must provide for a 60-day appeals process under section 14.57;

(6) the commissioner shall annually inflate the applicable organization encounter rates for FQHCs and rural health clinics from the base year payment rate to the effective date by using the CMS FQHC Market Basket inflator established under United States Code, title 42, section 1395m(o), less productivity;

(7) FQHCs and rural health clinics that have elected the alternative payment methodology under this paragraph shall submit all necessary documentation required by the commissioner to compute the rebased organization encounter rates no later than six months following the date the applicable Medicare cost reports are due to the Centers for Medicare and Medicaid Services;

(8) the commissioner shall reimburse FQHCs and rural health clinics an additional amount relative to their medical and dental organization encounter rates that is attributable to the tax required to be paid according to section 295.52, if applicable;

(9) FQHCs and rural health clinics may submit change of scope requests to the commissioner if the change of scope would result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate currently received by the FQHC or rural health clinic;

(10) for FQHCs and rural health clinics seeking a change in scope with the commissioner under clause (9) that requires the approval of the scope change by the federal Health Resources Services Administration:

(i) FQHCs and rural health clinics shall submit the change of scope request, including the start date of services, to the commissioner within seven business days of submission of the scope change to the federal Health Resources Services Administration;

(ii) the commissioner shall establish the effective date of the payment change as the federal Health Resources Services Administration date of approval of the FQHC's or rural health clinic's scope change request, or the effective start date of services, whichever is later; and

(iii) within 45 days of one year after the effective date established in item (ii), the commissioner shall conduct a retroactive review to determine if the actual costs established under clause (3) or encounters result in an increase or decrease of 2.5 percent or higher in the medical or dental organization encounter rate, and if this is the case, the commissioner shall revise the rate accordingly and shall adjust payments retrospectively to the effective date established in item (ii);

(11) for change of scope requests that do not require federal Health Resources Services Administration approval, the FQHC and rural health clinic shall submit the request to the commissioner before implementing the change, and the effective date of the change is the date the commissioner received the FQHC's or rural health clinic's request, or the effective start date of the service, whichever is later. The commissioner shall provide a response to the FQHC's or rural health clinic's request within 45 days of submission and provide a final approval within 120 days of submission. This timeline may be waived at the mutual agreement of the commissioner and the FQHC or rural health clinic if more information is needed to evaluate the request;

(12) the commissioner, when establishing organization encounter rates for new FQHCs and rural health clinics, shall consider the patient caseload of existing FQHCs and rural health clinics in a 60-mile radius for organizations established outside of the seven-county metropolitan area, and in a 30-mile radius for organizations in the seven-county metropolitan area. If this information is not available, the commissioner may use Medicare cost reports or audited financial statements to establish base rates;

(13) the commissioner, when establishing organization encounter rates under this section for FQHCs and rural health clinics resulting from a merger of existing clinics or the acquisition of an existing clinic by another existing clinic, must use the combined costs and caseloads from the clinics participating in the merger or acquisition to set the encounter rate for the new clinic organization resulting from the merger or acquisition. The scope of services for the newly formed clinic must be inclusive of the scope of services of the clinics participating in the merger or acquisition;

~~(13)~~ (14) the commissioner shall establish a quality measures workgroup that includes representatives from the Minnesota Association of Community Health Centers, FQHCs, and rural health clinics, to evaluate clinical and nonclinical measures; and

~~(14)~~ (15) the commissioner shall not disallow or reduce costs that are related to an FQHC's or rural health clinic's participation in health care educational programs to the extent that the costs are not accounted for in the alternative payment methodology encounter rate established in this paragraph.

(m) Effective July 1, 2023, an enrolled Indian health service facility or a Tribal health center operating under a 638 contract or compact may elect to also enroll as a Tribal FQHC. Requirements that otherwise apply to an FQHC covered in this subdivision do not apply to a Tribal FQHC enrolled under this paragraph, except that any requirements necessary to comply with federal regulations do apply to a Tribal FQHC. The commissioner shall establish an alternative payment method for a Tribal FQHC enrolled under this paragraph that uses the same method and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.

(n) FQHC reimbursement for mental health targeted case management services is limited to:

(1) only those services described under subdivision 20 and provided in accordance with contracts executed with counties authorized to subcontract for mental health targeted case management services; and

(2) an FQHC's actual incurred costs as separately reported on the cost report submitted to the Centers for Medicare and Medicaid Services and further identified in reports submitted to the commissioner.

(o) Counties contracting with FQHCs for mental health targeted case management remain responsible for the nonfederal share of the cost of the provided mental health targeted case management services. The commissioner must bill each county for the nonfederal share of the mental health targeted case management costs as reported by the FQHC.

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

Sec. 14. Minnesota Statutes 2024, section 256B.1973, subdivision 5, is amended to read:

Subd. 5. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall determine a uniform adjustment factor to be applied to each claim submitted by an eligible provider to a health plan. The uniform adjustment factor shall be determined using the average commercial payer rate or using another method acceptable to the Centers for Medicare and Medicaid Services if the average commercial payer rate is not approved, minus the amount necessary for the plan to satisfy tax liabilities under sections 256.9657 and 297I.05 attributable to the directed payment arrangement. The commissioner shall ensure that the application of the uniform adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and may use an annual settle-up process. The directed payment ~~shall~~ may be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(b) For each federally approved directed payment arrangement that is a state-directed fee schedule requirement, the commissioner shall develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that the eligible provider receives the entire permissible value of the federally approved directed payment arrangement. If federal approval of a directed payment arrangement under this subdivision is retroactive, the commissioner shall make a onetime pro rata increase to the uniform adjustment factor and the initial payments in order to include claims submitted between the retroactive federal approval date and the period captured by the initial payments.

Sec. 15. Minnesota Statutes 2024, section 256B.1973, is amended by adding a subdivision to read:

Subd. 9. **Interaction with other directed payments.** An eligible provider under subdivision 3 may participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. A provider participating in the hospital directed payment program must not receive a directed payment under this section for any provider classes paid via the hospital directed payment program. A hospital subject to this section must notify the commissioner in writing no later than 30 days after enactment of this subdivision of its intention to participate in the hospital directed payment program under section 256B.1974 for inpatient hospital services, outpatient hospital services, or both. The election under this subdivision is a onetime election, except that if an eligible provider elects to participate in the hospital directed payment program, and the hospital directed payment program expires, then the eligible provider may thereafter elect to participate in the directed payment under this section.

EFFECTIVE DATE. (a) This section is effective on the later of January 1, 2026, or federal approval of all of the following:

(1) the waiver for the assessment required under Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 16. **[256B.1974] HOSPITAL DIRECTED PAYMENT PROGRAM.**

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

(b) "Health plan" means a managed care plan or county-based purchasing plan that is under contract with the commissioner to deliver services to medical assistance enrollees under section 256B.69.

(c) "Eligible hospital" has the meaning given in section 256.9657, subdivision 2b, paragraph (a), clause (1).

Subd. 2. **Required conditions for program.** The hospital directed payment program is contingent on the satisfaction of all requirements necessary for the collection of an assessment under section 256.9657, and must conform with the requirements for permissible directed managed care organization expenditures under section 256B.6928, subdivision 5.

Subd. 3. **Commissioner's duties; state-directed fee schedule requirement.** (a) For each federally approved directed payment program that is a state-directed fee schedule requirement that includes a quarterly payment amount to be submitted by each health plan to each eligible hospital, the commissioner must determine the quarterly payment amount using the statewide average commercial payer rate, or using another method acceptable to the Centers for Medicare and Medicaid Services if the statewide average commercial payer rate is not approved. The commissioner must ensure that the application of the quarterly payment amounts maximizes the amount generated by the hospital assessment in section 256.9657, subdivision 2b, for allowable directed payments and does not result in payments exceeding federal limits.

(b) The commissioner must use an annual settle-up process that occurs within the time period allowed for medical assistance managed care claims adjustments.

(c) On and after January 1, 2028, if the federal regulations set forth in Code of Federal Regulations, title 42, parts 430, 438, and 457, remain effective, the hospital directed payment program may be specific to each health plan and prospectively incorporated into capitation payments for that plan.

(d) For each federally approved directed payment program that is a state-directed fee schedule requirement, the commissioner must develop a plan for the initial implementation of the state-directed fee schedule requirement to ensure that eligible hospitals receive the entire permissible value of the federally approved directed payment.

(e) Directed payments under this section must only be used to supplement, and not supplant, medical assistance reimbursement to eligible hospitals. The directed payment program must not modify, reduce, or offset the medical assistance payment rates determined for each eligible hospital as required by section 256.969.

(f) The commissioner must require health plans to make quarterly directed payments according to this section.

(g) Health plans must make quarterly directed payments using electronic funds transfers, if the eligible hospital provides the information necessary to process such transfers, and in accordance with directions provided by the commissioner. Health plans must make quarterly directed payments:

(1) for the first two quarters for which such payments are due, within 30 calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section; and

(2) for all subsequent quarters, within ten calendar days of the date the commissioner issued sufficient payments to the health plan to make the directed payments according to this section.

(h) The commissioner of human services must publish on the Department of Human Services website, on a quarterly basis, the dates that the health plans completed their required quarterly payments under this section.

(i) Payments to health plans that would be paid consistent with actuarial certification and enrollment in the absence of the increased capitation payments under this section must not be reduced as a result of this section.

(j) The commissioner must publish all directed payments resulting from this section owed to each eligible hospital from each health plan on the Department of Human Services website for at least two years. All calculations and reports must be posted no later than the first day of the quarter for which the payments are to be issued.

(k) By December 1 each year, the commissioner must notify each eligible hospital of any changes to the payment methodologies in this section, including but not limited to changes in the directed payment rates, the aggregate directed payment amount for all eligible hospitals, and the eligible hospital's directed payment amount for the upcoming calendar year.

(l) The commissioner must distribute payments required under this section for each eligible hospital within 30 days of a quarterly assessment under section 256.9657, subdivision 2b, being received. The commissioner must pay the directed payments to health plans under contract no later than January 1, April 1, July 1, and October 1 each year.

(m) A hospital is not entitled to payments under this section until it is an eligible hospital. An eligible hospital that has merged with another hospital must have its payments under this section revised at the start of the first full fiscal year after the merger is complete. A closed eligible hospital is entitled to the payments under this section for services provided through the final date of operations.

Subd. 4. **Health plan duties; submission of claims.** Each health plan must submit to the commissioner, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, payment information for each claim paid to an eligible hospital for services provided to a medical assistance enrollee. Health plans must allow each eligible hospital to review the health plan's own paid claims detail to enable proper validation that the medical assistance managed care claims volume and content is consistent with the eligible hospital's internal records. To support the validation process for the directed payment program, health plans must permit the commissioner to share inpatient and outpatient claims-level details with eligible hospitals identifying only those claims where the prepaid medical assistance program under section 256B.69 is the payer source. Eligible hospitals must provide notice of discrepancies in claims paid to the commissioner in a form determined by the commissioner. The commissioner is authorized to determine the final disposition of the validation process for disputed claims.

Subd. 5. **Health plan duties; directed payment add-on.** (a) Each health plan must make, in accordance with its contract with the commissioner to serve as a managed care organization in medical assistance, a directed payment to each eligible hospital. The amount of the directed payment to the eligible hospital must be equal to the payment amounts the plan received from the commissioner for the hospital.

(b) Health plans are prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with an eligible hospital in a manner that directly or indirectly takes into account a directed payment that a hospital receives under this section;

(2) unnecessarily delaying a directed payment to an eligible hospital; or

(3) recouping or offsetting a directed payment for any reason, except as expressly authorized by the commissioner.

Subd. 6. **Hospital duties; quarterly supplemental directed payment add-on.** (a) An eligible hospital receiving a directed payment under this section is prohibited from:

(1) setting, establishing, or negotiating reimbursement rates with a managed care organization in a manner that directly or indirectly takes into account a directed payment that an eligible hospital receives under this section; or

(2) directly passing on the cost of an assessment to patients or nonmedical assistance payers, including as a fee or rate increase.

(b) An eligible hospital that violates this subdivision is prohibited from receiving a directed payment under this section for the remainder of the calendar year. This subdivision does not prohibit an eligible hospital from negotiating with a payer for a rate increase.

(c) Any eligible hospital receiving a directed payment under this section must meet the commissioner's standards for directed payments as described in subdivision 7.

Subd. 7. **State minimum policy goals established.** (a) The effect of the directed payments under this section must align with the state's policy goals for medical assistance enrollees. The directed payments must be used to maintain quality and access to a full range of health care delivery mechanisms for medical assistance enrollees, and specifically provide improvement for one of the following quality measures:

(1) overall well child visit rates;

(2) maternal depression screening rates; or

(3) colon cancer screening rates.

(b) The commissioner, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a quality measures performance evaluation criteria and methodology to regularly measure access to care and the achievement of state policy goals described in this subdivision.

(c) The quality measures evaluation data, as determined by paragraph (b), must be reported to the Centers for Medicare and Medicaid Services after at least 12 months of directed payments to hospitals.

Subd. 8. **Administrative review.** Before making the payments required under this section, and on at least an annual basis, the commissioner must consult with and provide for review of the payment amounts by a permanent select committee established by the Minnesota Hospital Association. Any data or information reviewed by members of the committee are data not on individuals, as defined in section 13.02. The committee's members may not include any current employee or paid consultant of any hospital.

EFFECTIVE DATE. (a) This section is effective the later of January 1, 2026, or federal approval of all of the following:

(1) the amendments in this act adding Minnesota Statutes, section 256.9657, subdivision 2b; and

(2) the amendments in this act to this section.

(b) The commissioner of human services shall notify the revisor of statutes when federal approval for all amendments set forth in paragraph (a) is obtained.

Sec. 17. **[256B.1975] HOSPITAL DIRECTED PAYMENT PROGRAM ACCOUNT.**

Subdivision 1. **Account established; appropriation.** (a) The hospital directed payment program account is created in the special revenue fund in the state treasury.

(b) Money in the account, including interest earned, is annually appropriated to the commissioner for the purposes specified in section 256B.1974.

(c) Transfers from this account to another fund are prohibited, except as necessary to make the payments required under section 256B.1974.

Subd. 2. **Reports to the legislature.** By January 15, 2027, and each January 15 thereafter, the commissioner must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance that details the activities and uses of money in the hospital directed payment program account, including the metrics and outcomes of the policy goals established by section 256B.1974, subdivision 7.

EFFECTIVE DATE. This section is effective on the later of January 1, 2026, or federal approval of the amendments in this act adding Minnesota Statutes, section 256.9657, subdivision 2b. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 18. Minnesota Statutes 2024, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing the medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must

be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 142F and 145A and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance benefit set. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance program in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment. This paragraph expires upon the effective date of paragraph (d).

(d) For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. This paragraph is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

~~(d)~~ (e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

~~(e)~~ (f) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.

~~(f)~~ (g) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.

~~(g)~~ (h) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

~~(h)~~ (i) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

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

Sec. 19. **[256B.695] COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE PROGRAM.**

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

(b) "CARMA" means the county-administered rural medical assistance program established under this section.

(c) "Commissioner" means the commissioner of human services.

(d) "Eligible individual" means an individual who is:

(1) residing in a county administering CARMA; and

(2) eligible for medical assistance, MinnesotaCare, Minnesota Senior Health Options (MSHO), Minnesota Senior Care Plus (MSC+), or Special Needs Basic Care (SNBC).

(e) "Enrollee" means an individual enrolled in CARMA.

(f) "PMAP" means the prepaid medical assistance program under section 256B.69.

(g) "Rural county" has the meaning given to "rural area" in Code of Federal Regulations, title 42, section 438.52.

Subd. 2. **Program established.** CARMA is established to:

(1) provide a county-owned and county-administered alternative to PMAP;

(2) facilitate integration of health care, public health, and social services to address health-related social needs in rural communities;

(3) account for the fewer enrollees and local providers of health care and community services in rural communities; and

(4) promote accountability for health outcomes, health equity, customer service, community outreach, and cost of care.

Subd. 3. **County participation.** Each county or group of counties authorized under section 256B.692 may administer CARMA for any or all eligible individuals as an alternative to PMAP, MinnesotaCare, MSHO, MSC+, or SNBC programs. Counties choosing and authorized to administer CARMA are exempt from the procurement process as required under section 256B.69.

Subd. 4. **Oversight and regulation.** CARMA is governed by sections 256B.69 and 256B.692, unless otherwise provided for under this section. The commissioner must develop and implement a procurement process requiring applications from county-based purchasing plans interested in offering CARMA. The procurement process must require county-based purchasing plans to demonstrate compliance with federal and state regulatory requirements and the ability to meet the goals of the program set forth in subdivision 2. The commissioner must review and approve or disapprove applications.

Subd. 5. **CARMA enrollment.** (a) Subject to paragraphs (d) and (e), eligible individuals must be automatically enrolled in CARMA, but may decline enrollment. Eligible individuals may enroll in fee-for-service medical assistance. Eligible individuals may change their CARMA elections on an annual basis.

(b) Eligible individuals must be able to enroll in CARMA through the selection process in accordance with the election period established in section 256B.69, subdivision 4, paragraph (e).

(c) Enrollees who were not previously enrolled in the medical assistance program or MinnesotaCare can change their selection once within the first year after enrollment in CARMA. Enrollees who were not previously enrolled in CARMA have 90 days to make a change and changes are allowed for additional special circumstances.

(d) The commissioner may offer a second health plan other than, and in addition to, CARMA to eligible individuals when another health plan is required by federal law or rule. The commissioner may offer a replacement plan to eligible individuals, as determined by the commissioner, when counties administering CARMA have their contract terminated for cause.

(e) The commissioner may, on a county-by-county basis, offer a health plan other than, and in addition to, CARMA to individuals who are eligible for both Medicare and medical assistance due to age or disability if the commissioner deems it necessary for enrollees to have another choice of health plan. Factors the commissioner must consider when determining if the other health plan is necessary include the number of available Medicare Advantage Plan options that are not special needs plans in the county, the size of the enrolling population, the additional administrative burden placed on providers and counties by multiple health plan options in a county, the need to ensure the viability and success of the CARMA program, and the impact to the medical assistance program.

(f) In counties where the commissioner is required by federal law or elects to offer a second health plan other than CARMA pursuant to paragraphs (d) and (e), eligible enrollees who do not select a health plan at the time of enrollment must automatically be enrolled in CARMA.

(g) This subdivision supersedes section 256B.694.

Subd. 6. **Benefits and services.** (a) Counties or groups of counties administering CARMA must cover all benefits and services required to be covered by medical assistance under section 256B.0625.

(b) Counties or groups of counties administering CARMA may include health-related social needs (HRSN) benefits as covered services under medical assistance as of January 1, 2030. Coverage for HRSN must be based on the assessed needs of housing, food, transportation, utilities, and interpersonal safety.

(c) Counties or groups of counties administering CARMA may reimburse enrollees directly for out-of-pocket costs incurred obtaining assessed HRSN services provided by nontraditional providers who are unable to accept payment via traditional health insurance methods. Enrollees must not be reimbursed for out-of-pocket costs paid to providers eligible to enroll.

Subd. 7. **Payment.** (a) The commissioner, in consultation with counties and groups of counties administering CARMA, must develop a mechanism for making payments to counties and groups of counties that administer CARMA. The payment mechanism must:

(1) be governed by contracts with terms, including but not limited to payment rates, amended on an as-needed basis;

(2) pay a full-risk monthly capitation payment for services included in CARMA, including the cost for administering CARMA benefits and services;

(3) include risk corridors based on minimum loss ratio, total cost of care, or other metrics;

(4) include a settle-up process tied to the risk corridor arrangement allowing a county or group of counties administering CARMA to retain savings for reinvestment in health care activities and operations to protect against significant losses that a county or group of counties administering CARMA or the state might realize, beginning no sooner than after a county's or group of counties' third year of CARMA operations;

(5) include a collaborative rate-setting process accounting for CARMA experience, regional experience, and the Department of Human Services fee-for-service experience; and

(6) be exempt from section 256B.69, subdivisions 5a, paragraphs (c) and (f), and 5d, and payment for Medicaid services provided under section 256B.69, subdivision 28, paragraph (b), no sooner than three years after CARMA implementation.

(b) Payments for benefits and services under subdivision 6, paragraph (a), must not exceed payments that otherwise would have been paid to health plans under medical assistance for that county or region. Payments for HRSN benefits under subdivision 6, paragraph (b), must be in addition to payments for benefits and services under subdivision 6, paragraph (a).

Subd. 8. **Quality measures.** (a) The commissioner and counties and groups of counties administering CARMA must collaborate to establish quality measures for CARMA not to exceed the extent of quality measures required under sections 256B.69 and 256B.692. The measures must include:

(1) enrollee experience and outcomes;

(2) population health;

(3) health equity; and

(4) the value of health care spending.

(b) The commissioner and counties and groups of counties administering CARMA must collaborate to define a quality improvement model for CARMA. The model must include a focus on locally specified measures based on counties' unique needs. The locally specified measures for the county or group of counties administering CARMA must be determined before the commissioner enters into any contract with a county or group of counties.

Subd. 9. **Data and systems integration.** The commissioner and counties and groups of counties administering CARMA must collaborate to:

(1) identify and address barriers that prevent counties and groups of counties administering CARMA from reviewing individual enrollee eligibility information to identify eligibility and to help enrollees apply for other appropriate programs and resources;

(2) identify and address barriers preventing counties and groups of counties administering CARMA from more readily communicating with and educating potential and current enrollees regarding other program opportunities, including helping enrollees apply for those programs and navigate transitions between programs;

(3) develop and test, in counties participating in CARMA, a universal public assistance application form to reduce the administrative barriers associated with applying for and participating in various public programs;

(4) identify and address regulatory and system barriers that may prohibit counties and groups of counties administering CARMA, agencies, and other partners from working together to identify and address an individual's needs;

(5) facilitate greater interoperability between counties and groups of counties administering CARMA, agencies, and other partners to send and receive the data necessary to support CARMA, counties, and local health system efforts to improve the health and welfare of prospective and enrolled populations;

(6) support efforts of counties and groups of counties administering CARMA to incorporate the necessary automation and interoperability to eliminate manual processes when related to the data exchanged; and

(7) support the creation and maintenance by counties and groups of counties administering CARMA of an updated electronic inventory of community resources available to assist the enrollee in the enrollee's HRSN, including an electronic closed-loop referral system.

EFFECTIVE DATE. This section is effective January 1, 2027, or upon federal approval, whichever is later. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

Sec. 20. **IMPLEMENTATION OF HOSPITAL ASSESSMENT AND DIRECTED PAYMENT PROGRAM.**

(a) The commissioner of human services must immediately begin all necessary claims analysis to calculate the assessment and payments required under Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program described in Minnesota Statutes, section 256B.1974.

(b) The commissioner of human services, in consultation with the Minnesota Hospital Association, must submit to the Centers for Medicare and Medicaid Services a request for federal approval to implement the hospital assessment described in Minnesota Statutes, section 256.9657, subdivision 2b, and the hospital directed payment program under Minnesota Statutes, section 256B.1974. At least 15 days before submitting the request for approval, the commissioner must make available to the public the draft assessment requirements, the draft directed payment details, and an estimate of each assessment amount for each eligible hospital without an exemption from the assessment pursuant to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k).

(c) During the design and prior to submission of the request for approval under paragraph (b), the commissioner of human services must consult with the Minnesota Hospital Association and any eligible hospitals without an exemption from the assessment pursuant to Minnesota Statutes, section 256.9657, subdivision 2b, paragraph (k), and that are not members of the Minnesota Hospital Association.

(d) If federal approval is received for the request under paragraph (b), the commissioner of human services must provide at least 15 days of public posting and review of the federally approved terms and conditions for the assessment and the directed payment program prior to any assessment under Minnesota Statutes, section 256.9657, subdivision 2b, becoming due from an eligible hospital.

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

Sec. 21. **REQUEST FOR FEDERAL WAIVER.**

The commissioner of human services must seek all federal waivers and authority necessary to implement the county-assisted rural medical assistance (CARMA) program under Minnesota Statutes, section 256B.695. Any part of the CARMA program that does not require federal approval shall have an effective date as specified in state law. The commissioner of human services shall notify the revisor of statutes when federal approval is obtained.

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

Sec. 22. **COUNTY-ADMINISTERED RURAL MEDICAL ASSISTANCE PROGRAM IMPLEMENTATION COSTS.**

Up to $500,000 of the nonfederal share of the costs to the Department of Human Services for implementation of the requirements under the county-assisted rural medical assistance (CARMA) program under Minnesota Statutes, section 256B.695, must be paid via an intergovernmental funds transfer to the commissioner of human services by each county or group of counties authorized under Minnesota Statutes, section 256B.692, seeking to administer a CARMA program. The costs must be paid in a manner that is in compliance with the requirements of Code of Federal Regulations, title 42, section 433.51. Within one year of receiving payment under this section, the commissioner must provide a settle-up process for any county or group of counties authorized under Minnesota Statutes, section 256B.692, administering a CARMA program and making payment under this section to document and adjust payments owed to account for the commissioner's actual implementation costs for Minnesota Statutes, section 256B.695.

Sec. 23. **MEDICAL ASSISTANCE COVERAGE OF TRADITIONAL HEALTH CARE PRACTICES.**

Subdivision 1. **Waiver request.** By October 1, 2025, the commissioner of human services, in consultation with Tribes, Tribal organizations, and urban Indian organizations, shall apply to the Centers for Medicare and Medicaid Services for a waiver to allow the state's medical assistance program to provide coverage for traditional health care practices received through Indian health service facilities, facilities operated by Tribes or Tribal organizations under the Indian Self-Determination and Education Assistance Act, or facilities operated by urban Indian organizations under Title V of the Indian Health Care Improvement Act.

Subd. 2. **Requirements.** (a) A qualified provider must determine whether a medical assistance enrollee is eligible to receive traditional health care practices under this section.

(b) Traditional health care practices are covered under this section if they are received from a qualified provider.

(c) For purposes of this section, "qualified provider" means a practitioner or provider who is employed by or under contract with the Indian Health Service, a 638 Tribal clinic, or a Title V urban Indian organization. Each facility is responsible for ensuring that a qualified provider has the necessary experience and appropriate training to provide traditional health care practices.

Subd. 3. **Payments for traditional health care practices.** Reimbursement for traditional health care practices under this section is set at the outpatient, per-visit rate established by the Indian Health Service under sections 321(a) and 322(b) of the Public Health Service Act. Reimbursement is limited to one payment per day, per medical assistance enrollee receiving traditional health care practices.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later, except that subdivision 1 is effective the day following final enactment. The commissioner of human services must notify the revisor of statutes when federal approval is obtained.

Sec. 24. **DIRECTION TO COMMISSIONER OF HUMAN SERVICES; ENHANCED FEDERAL REIMBURSEMENT FOR FAMILY PLANNING SERVICES IN MEDICAL ASSISTANCE.**

The commissioner of human services must make the systems modification necessary to claim enhanced federal reimbursement for all family planning services under the medical assistance program.

Sec. 25. **DENTAL ACCESS WORKING GROUP.**

Subdivision 1. **Establishment.** (a) The commissioner of human services must establish a working group as part of the Dental Services Advisory Committee to identify and make recommendations on the state's goals, priorities, and processes for contracting with a dental administrator under Minnesota Statutes, section 256B.0371.

(b) The working group must include members of the Dental Services Advisory Committee, and at least one representative from each of the following:

(1) critical access dental providers;

(2) dental providers that primarily serve low-income and socioeconomically complex populations;

(3) dental providers that serve private-pay patients as well as medical assistance and MinnesotaCare enrollees;

(4) rural critical access dental providers that do not have clinics in the seven-county metropolitan area as defined in Minnesota Statutes, section 473.121, subdivision 2; and

(5) managed care plans.

Subd. 2. **Recommendations.** (a) The working group must provide recommendations to the commissioner on:

(1) establishing and implementing a dental payment rate structure for medical assistance and MinnesotaCare that:

(i) is based on the most recent cost data available;

(ii) promotes accountability while considering geographic differences in access to and cost of dental services, critical access dental status, patient characteristics, transportation needs, and medical and dental benefit coordination; and

(iii) can be updated regularly;

(2) performance benchmarks that focus on improving oral health for medical assistance and MinnesotaCare enrollees, including consideration of Dental Quality Alliance and Oral Health Impact Profile measures for broader assessment of a full range of services, and the feasibility, cost, and value of providing the services;

(3) methods for measuring progress toward the performance benchmarks and holding the dental administrator accountable for progress, including providing rewards for progress;

(4) establishing goals and processes to ensure coordination of care among medical assistance and MinnesotaCare providers, including dental, medical, and other care providers, particularly for patients with complex cases engaged in active treatment plans at the time of transition to the dental administrator under Minnesota Statutes, section 256B.0371;

(5) developing and implementing an infrastructure and workforce development strategy that invests in the medical assistance and MinnesotaCare dental system through grants and loans at a level that enables continued development of dental capacity commensurate with that obtained through the managed care delivery system and from philanthropic sources; and

(6) developing and implementing a workforce development strategy to support the pipeline of dental providers and oral health practitioners at all levels.

(b) The working group must provide the recommendations required under this subdivision to the commissioner by.....

Subd. 3. **Reporting requirements.** (a) By....., the commissioner, in consultation with its contracted dental administrator, must develop an implementation plan and timeline to effectuate the recommendations from the working group under this section.

(b) By....., the commissioner must submit a report with the working group recommendations, implementation plan, timeline, and any draft legislation required to implement the implementation plan to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

Sec. 26. **REPEALER.**

(a) Laws 2023, chapter 70, article 16, section 22, is repealed.

(b) Minnesota Statutes 2024, section 256B.0625, subdivisions 18b, 18e, and 18h, are repealed.

EFFECTIVE DATE. Paragraph (b) is effective July 1, 2026, for medical assistance fee-for-service and January 1, 2027, for prepaid medical assistance.

ARTICLE 6
OFFICE OF EMERGENCY MEDICAL SERVICES

Section 1. **[144E.54] AMBULANCE OPERATING DEFICIT GRANT PROGRAM.**

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

(b) "Capital expenses" means expenses incurred by a licensee for the purchase, improvement, or maintenance of assets with an expected useful life of greater than five years that improve the efficiency of provided ambulance services or the capabilities of the licensee.

(c) "Eligible applicant" or "eligible licensee" means any licensee who possessed a license not excluded under subdivision 4 or 5 in the last completed state fiscal year for which data was provided to the director, as provided in section 62J.49; who continues to operate that same nonexcluded license at the time of application; and who provides verifiable evidence of an operating deficit in the state fiscal year prior to submitting an application.

(d) "Government licensee" means any government entity, as defined in section 118A.01, subdivision 2, including a Tribe, that is a licensee.

(e) "Insurance revenue" means revenue from Medicare, medical assistance, private health insurance, third-party liability insurance, and payments from individuals.

(f) "Operating deficit" means the sum of insurance revenue and other revenue is less than the sum of operational expenses and capital expenses.

(g) "Operational expenses" means costs related to the day-to-day operations of an ambulance service, including but not limited to costs related to personnel, supplies and equipment, fuel, vehicle maintenance, travel, education, and fundraising.

(h) "Other revenue" means revenue from any revenue that is not insurance revenue, including but not limited to grants, tax revenue, donations, fundraisers, or standby fees.

Subd. 2. **Program establishment.** An ambulance operating deficit grant program is established to award grants to applicants to address revenue shortfalls creating operating deficits among eligible applicants.

Subd. 3. **Licensee providing specialized life support services excluded.** Licensees providing specialized life support services as described in section 144E.101, subdivision 9, are not eligible for grants under this section.

Subd. 4. **Other licensees excluded.** Licensees whose individual primary service areas are located mostly within a metropolitan county listed in section 473.121, subdivision 4, or within the cities of Duluth, Mankato, St. Cloud, or Rochester are not eligible for grants under this section.

Subd. 5. **Application process.** (a) An eligible licensee may apply to the director, in the form and manner determined by the director, for a grant under this section.

(b) A grant application made by a government licensee must be accompanied by a resolution of support from the governing body.

Subd. 6. **Director calculations.** The director shall award grants only to applicants who provide verifiable evidence of an operating deficit in the last completed state fiscal year for which data were provided to the director. The director may audit the financial data provided to the director by applicants, as provided in section 62J.49. A grant awarded must not be more than five percent more than any previous grant without special permission from the director.

Subd. 7. **Grant awards; limitations.** (a) Grants awarded under this section to eligible applicants may be proportionally distributed based on money available. Total amounts awarded must not exceed the amount in the ambulance operating deficit account.

(b) The director shall award grants annually.

(c) The director must not award individual grants that exceed the amount of the grantee's most recent verified operating deficit as reported to the director.

Subd. 8. **Eligible expenditures.** A grantee must spend grant money received under this section on operational expenses and capital expenses incurred to provide ambulance services.

Subd. 9. **Report.** By February 15, 2026, and annually thereafter, the director must submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance and policy. The report must describe the number and amount of grants awarded under this section and the uses made of grant money by grantees.

Sec. 2. **[144E.55] RURAL EMS UNCOMPENSATED CARE POOL PAYMENT PROGRAM.**

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

(b) "Eligible licensee" means a licensee that primarily provides ambulance services outside the metropolitan counties listed in section 473.121, subdivision 4.

(c) "Public safety answering point" has the meaning given in section 403.02, subdivision 19.

Subd. 2. **Payment program established.** The director must establish and administer a rural EMS uncompensated care pool payment program. Under the program, the director must make payments to eligible licensees according to this section.

Subd. 3. **Excluded responses.** The director must exclude EMS responses by specialized life support, as described in section 144E.101, subdivision 9, in calculating payments under this section.

Subd. 4. **Application process.** (a) An eligible licensee seeking a payment under this section must apply to the director each year by March 31, in the form and manner determined by the director. In the application, the eligible licensee must specify the number of the eligible licensee's EMS responses that meet the criteria in subdivision 5.

(b) When an eligible licensee, an eligible licensee's parent company, a subsidiary of an eligible licensee, or a subsidiary of an eligible licensee's parent company collectively hold multiple licenses, the director must treat all such related licensees as a single eligible licensee.

Subd. 5. **Eligible EMS responses.** In order for an EMS response to be an eligible EMS response for purposes of subdivision 6, the EMS response must meet the following criteria:

(1) the EMS response was initiated by a request for emergency medical services initially received by a public safety answering point;

(2) an ambulance responded to the scene;

(3) the ambulance was not canceled while en route to the scene;

(4) the ambulance did not transport a person from the scene to a hospital emergency department;

(5) the eligible licensee did not receive any payment for the EMS response from any source; and

(6) the EMS response was initiated between January 1 and December 31 of the year prior to the year the application is submitted.

Subd. 6. **Calculations.** (a) The director must calculate payments as provided in paragraphs (b) and (c) for an eligible licensee that completes an application under subdivision 4.

(b) The director must award points for eligible EMS responses as follows:

(1) for eligible EMS responses one to 25, an eligible licensee is awarded ten points per response;

(2) for eligible EMS responses 26 to 50, an eligible licensee is awarded five points per response;

(3) for eligible EMS responses 51 to 100, an eligible licensee is awarded three points per response;

(4) for eligible EMS responses 101 to 200, an eligible licensee is awarded one point per response; and

(5) for eligible EMS responses exceeding 200, an eligible licensee is awarded zero points.

(c) The director must total the number of all points awarded to all applying eligible licensees under paragraph (b). The director must divide the amount appropriated for purposes of this section by the total number of points awarded to determine a per-point amount. The payment for each eligible licensee shall be calculated by multiplying the eligible licensee's number of awarded points by the established per-point amount.

Subd. 7. **Payment.** The director must certify the payment amount for each eligible licensee and must make the full payment to each eligible licensee by May 30 each year.

ARTICLE 7
ECONOMIC ASSISTANCE

Section 1. Minnesota Statutes 2024, section 142A.03, is amended by adding a subdivision to read:

Subd. 35. **Electronic benefits transfer; contracting and procurement.** Notwithstanding chapter 16C, the commissioner is exempt from the contract term limits for the issuance of public benefits through an electronic benefit transfer system and related services. These contracts may have up to an initial five-year term, with extensions not to exceed a ten-year total contract duration.

Sec. 2. Minnesota Statutes 2024, section 142F.14, is amended to read:

142F.14 FOOD SHELF.

Subdivision 1. **Distribution of appropriation.** The commissioner must distribute funds appropriated to the commissioner ~~by law for that purpose~~ for purposes of this section to ~~Hunger Solutions~~ The Food Group, a statewide association of food shelves organized as a nonprofit corporation as defined under section 501(c)(3) of the Internal Revenue Code of 1986, to distribute to qualifying food shelves. A food shelf qualifies under this section if:

(1) it is a nonprofit corporation, or is affiliated with a nonprofit corporation, as defined in section 501(c)(3) of the Internal Revenue Code of 1986 or a federally recognized Tribal nation;

(2) it distributes standard food orders without charge to needy individuals. The standard food order must consist of at least a two-day supply or six pounds per person of nutritionally balanced food items;

(3) it does not limit food distributions to individuals of a particular religious affiliation, race, or other criteria unrelated to need or to requirements necessary to administration of a fair and orderly distribution system;

(4) it does not use the money received or the food distribution program to foster or advance religious or political views; and

(5) it has a stable address and directly serves individuals.

Subd. 2. **Application.** In order to receive money appropriated under this section, ~~Hunger Solutions~~ The Food Group must apply to the commissioner. The application must be in a form prescribed by the commissioner and must indicate the proportion of money each qualifying food shelf shall receive. Applications must be filed at the times and for the periods determined by the commissioner.

Subd. 3. **Distribution formula.** ~~Hunger Solutions~~ The Food Group must distribute money distributed to it by the department to food shelf programs in proportion to the number of individuals served by each food shelf program. The commissioner must gather data from ~~Hunger Solutions~~ The Food Group or other appropriate sources to determine the proportionate amount each qualifying food shelf program is entitled to receive. The commissioner may increase or decrease the qualifying food shelf program's proportionate amount if the commissioner determines the increase or decrease is necessary or appropriate to meet changing needs or demands.

Subd. 4. **Use of money.** At least 96 percent of the money distributed to ~~Hunger Solutions~~ The Food Group under this section must be distributed to food shelf programs to purchase, transport, and coordinate the distribution of nutritious food to needy individuals and families. The money distributed to food shelf programs may also be used to purchase personal hygiene products, including but not limited to diapers and toilet paper. No more than four percent of the money may be expended for other expenses, such as rent, salaries, and other administrative expenses of ~~Hunger Solutions~~ The Food Group.

Subd. 5. **Enforcement.** ~~Hunger Solutions~~ The Food Group must retain records documenting expenditure of the money and comply with any additional requirements imposed by the commissioner. The commissioner may require ~~Hunger Solutions~~ The Food Group to report on its use of the funds. The commissioner may require that the report contain an independent audit. If ineligible expenditures are made by ~~Hunger Solutions~~ The Food Group, the ineligible amount must be repaid to the commissioner and deposited in the general fund.

Subd. 6. **Administrative expenses.** All funds appropriated under this section must be distributed to ~~Hunger Solutions~~ The Food Group as provided under this section with deduction by the commissioner for administrative expenses limited to 1.8 percent.

Subd. 7. **Data classification.** Data collected on individuals from which the identity of any individual receiving services may be determined are private data on individuals as defined in section 13.02.

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

ARTICLE 8
CHILD PROTECTION AND WELFARE POLICY

Section 1. Minnesota Statutes 2024, section 142B.01, subdivision 15, is amended to read:

Subd. 15. **Individual who is related.** "Individual who is related" means a spouse, a parent, a birth or adopted child or stepchild, a stepparent, a stepbrother, a stepsister, a niece, a nephew, an adoptive parent, a grandparent, a sibling, an aunt, an uncle, or a legal guardian. For purposes of family child foster care, individual who is related also includes an individual who, prior to the child's placement in the individual's home for foster care or adoption, was an important friend of the child or of the child's parent or custodian, including an individual with whom the child has resided or had significant contact or who has a significant relationship to the child or the child's parent or custodian.

Sec. 2. Minnesota Statutes 2024, section 142B.05, subdivision 3, is amended to read:

Subd. 3. **Foster care by an individual who is related to a child; license required.** (a) Notwithstanding subdivision 2, paragraph (a), clause (1), in order to provide foster care for a child, an individual who is related to the child, other than a parent, or legal guardian, must be licensed by the commissioner except as provided by section 142B.06.

(b) An individual who is related to the child may seek foster care licensure through the county agency or a private agency in the community licensed and authorized by the commissioner. The placing agency must provide information to all potential relative foster care providers about this choice. Counties are not obligated to pay costs for services provided by private agencies.

(c) If an individual who is related to a child is seeking licensure to provide foster care for the child and the individual has a domestic partner but is not married to the domestic partner, only the individual related to the child must be licensed to provide foster care. The commissioner must conduct background studies on household members according to section 245C.03, subdivision 1.

Sec. 3. Minnesota Statutes 2024, section 142B.47, is amended to read:

142B.47 TRAINING ON RISK OF SUDDEN UNEXPECTED INFANT DEATH AND ABUSIVE HEAD TRAUMA FOR CHILD FOSTER CARE PROVIDERS.

(a) Licensed child foster care providers, except individuals related to the child, that care for infants or children through five years of age must document that before caregivers assist in the care of infants or children through five years of age, ~~they~~ the caregivers are instructed on the standards in section 142B.46 and receive training on reducing the risk of sudden unexpected infant death and abusive head trauma from shaking infants and young children. Licensed child foster care providers who are related to the child and who only serve a relative child must document completion of the training required under this section within 30 days after licensure. This section does not apply to emergency relative placement under section 142B.06. The training on reducing the risk of sudden unexpected infant death and abusive head trauma may be provided as:

(1) orientation training to child foster care providers who care for infants or children through five years of age under Minnesota Rules, part 2960.3070, subpart 1; or

(2) in-service training to child foster care providers who care for infants or children through five years of age under Minnesota Rules, part 2960.3070, subpart 2.

(b) Training required under this section must be at least one hour in length and must be completed at least once every five years. At a minimum, the training must address the risk factors related to sudden unexpected infant death and abusive head trauma, means of reducing the risk of sudden unexpected infant death and abusive head trauma, and license holder communication with parents regarding reducing the risk of sudden unexpected infant death and abusive head trauma.

(c) Training for child foster care providers must be approved by the county or private licensing agency that is responsible for monitoring the child foster care provider under section 142B.30. The approved training fulfills, in part, training required under Minnesota Rules, part 2960.3070.

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

Sec. 4. Minnesota Statutes 2024, section 142B.51, subdivision 2, is amended to read:

Subd. 2. **Child passenger restraint systems; training requirement.** (a) Programs licensed by the Department of Human Services under chapter 245A or the Department of Children, Youth, and Families under this chapter and Minnesota Rules, chapter 2960, that serve a child or children under eight years of age must document training that fulfills the requirements in this subdivision.

(b) Before a license holder, staff person, or caregiver transports a child or children under age eight in a motor vehicle, the person transporting the child must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this section may be used to meet initial or ongoing training under Minnesota Rules, part 2960.3070, subparts 1 and 2.

(c) Training required under this section must be completed at orientation or initial training and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(d) Training under paragraph (c) must be provided by individuals who are certified and approved by the Office of Traffic Safety within the Department of Public Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

(e) Notwithstanding paragraph (a), for an emergency relative placement under section 142B.06, the commissioner may grant a variance to the training required by this subdivision for a relative who completes a child seat safety check up. The child seat safety check up trainer must be approved by the Department of Public Safety, Office of Traffic Safety, and must provide one-on-one instruction on placing a child of a specific age in the exact child passenger restraint in the motor vehicle in which the child will be transported. Once granted a variance, and if all other licensing requirements are met, the relative applicant may receive a license and may transport a relative foster child younger than eight years of age. A child seat safety check up must be completed each time a child requires a different size car seat according to car seat and vehicle manufacturer guidelines. A relative license holder must complete training that meets the other requirements of this subdivision prior to placement of another foster child younger than eight years of age in the home or prior to the renewal of the child foster care license.

(f) Notwithstanding paragraph (b), a child foster care license holder who is an individual related to the child and who only serves a relative child must document completion of the training required under this section within 30 days after licensure.

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

Sec. 5. Minnesota Statutes 2024, section 142B.80, is amended to read:

142B.80 CHILD FOSTER CARE TRAINING REQUIREMENT; MENTAL HEALTH TRAINING; FETAL ALCOHOL SPECTRUM DISORDERS TRAINING.

Prior to a nonemergency placement of a child in a foster care home, the child foster care license holder and caregivers in foster family and treatment foster care settings must complete two hours of training that addresses the causes, symptoms, and key warning signs of mental health disorders; cultural considerations; and effective approaches for dealing with a child's behaviors. At least one hour of the annual training requirement for the foster family license holder and caregivers must be on children's mental health issues and treatment. Except for providers and services under chapter 245D and child foster care license holders who are individuals related to the child and who only serve a relative child who does not have fetal alcohol spectrum disorder, the annual training must also include at least one hour of training on fetal alcohol spectrum disorders, which must be counted toward the 12 hours of required in-service training per year. Short-term substitute caregivers are exempt from these requirements. Training curriculum shall be approved by the commissioner of children, youth, and families.

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

Sec. 6. **[142B.81] CHILD FOSTER CARE TRAINING; RELATIVE CAREGIVERS.**

Notwithstanding the required hours under Minnesota Rules, part 2960.3070, subpart 2, a child foster care license holder who is an individual related to the child must complete a minimum of six hours of in-service training per year in one or more of the areas in Minnesota Rules, part 2960.3070, subpart 2, or in other areas as agreed upon by the licensing agency and the foster parent. The relative child foster care license holder must consult with the licensing agency and complete training in areas that are most applicable to caring for the relative children in foster care in the home. This section does not apply to a child foster care license holder who is licensed to care for both a relative child and a nonrelative child.

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

Sec. 7. Minnesota Statutes 2024, section 245C.02, is amended by adding a subdivision to read:

Subd. 16b. **Relative.** "Relative" has the meaning given in section 260C.007, subdivision 27. For purposes of background studies affiliated with child foster care licensure, a person is a relative if the person was known to the child or the child's parent before the child is placed in foster care.

Sec. 8. Minnesota Statutes 2024, section 260.65, is amended to read:

260.65 NONCUSTODIAL PARENTS; RELATIVE PLACEMENT.

(a) Prior to the removal of an African American or a disproportionately represented child from the child's home, the responsible social services agency must make active efforts to identify and locate the child's noncustodial or nonadjudicated parent and the child's relatives to notify the child's parent and relatives that the child is or will be placed in foster care~~,~~ and provide the child's parent and relatives with a list of legal resources. The notice to the child's noncustodial or nonadjudicated parent and relatives must also include the information required under section 260C.221, subdivision 2, paragraph (b). The responsible social services agency must maintain detailed records of the agency's efforts to notify parents and relatives under this section.

(b) Notwithstanding the provisions of section 260C.219, the responsible social services agency must assess an African American or a disproportionately represented child's noncustodial or nonadjudicated parent's ability to care for the child before placing the child in foster care. If a child's noncustodial or nonadjudicated parent is willing and able to provide daily care for the African American or disproportionately represented child temporarily or permanently, the court shall order ~~that~~ the child ~~be placed in~~ into the home of the noncustodial or nonadjudicated parent pursuant to section 260C.178 or 260C.201, subdivision 1. The responsible social services agency must make active efforts to assist a noncustodial or nonadjudicated parent with remedying any issues that may prevent the child from being ~~placed with the~~ ordered into the home of a noncustodial or nonadjudicated parent.

(c) The relative search, notice, engagement, and placement consideration requirements under section 260C.221 apply under this act.

Sec. 9. Minnesota Statutes 2024, section 260.66, subdivision 1, is amended to read:

Subdivision 1. **Emergency removal or placement permitted.** Nothing in this section shall be construed to prevent the emergency removal of an African American or a disproportionately represented ~~child's parent or custodian~~ child or the emergency placement of the child in a foster setting in order to prevent imminent physical damage or harm to the child.

Sec. 10. Minnesota Statutes 2024, section 260.691, subdivision 1, is amended to read:

Subdivision 1. **Establishment and duties.** (a) The African American Child and Family Well-Being Advisory Council is established for the Department of Children, Youth, and Families.

(b) The council shall consist of 31 members appointed by the commissioner and must include representatives with lived personal or professional experience within African American communities. Members may include but are not limited to youth who have exited the child welfare system; parents; legal custodians; relative and kinship caregivers or foster care providers; community service providers, advocates, and members; county and private social services agency case managers; representatives from faith-based institutions; academic professionals; a representative from the Council for Minnesotans of African Heritage; the Ombudsperson for African American Families; and other individuals with experience and knowledge of African American communities. Council members must be selected through an open appointments process under section 15.0597. The terms, compensation, and removal of council members are governed by section 15.059.

(c) The ~~African American Child Well-Being Advisory~~ council must:

(1) review annual reports related to African American children involved in the child welfare system. These reports may include but are not limited to the maltreatment, out-of-home placement, and permanency of African American children;

(2) assist with and make recommendations to the commissioner for developing strategies to reduce maltreatment determinations, prevent unnecessary out-of-home placement, promote culturally appropriate foster care and shelter or facility placement decisions and settings for African American children in need of out-of-home placement, ensure timely achievement of permanency, and improve child welfare outcomes for African American children and their families;

(3) review summary reports on targeted case reviews prepared by the commissioner to ensure that responsible social services agencies meet the needs of African American children and their families. Based on data collected from those reviews, the council shall assist the commissioner with developing strategies needed to improve any identified child welfare outcomes, including but not limited to maltreatment, out-of-home placement, and permanency for African American children;

(4) ~~assist the Cultural and Ethnic Communities Leadership Council with making~~ make recommendations to the commissioner and the legislature for public policy and statutory changes that specifically consider the needs of African American children and their families involved in the child welfare system;

(5) advise the commissioner on stakeholder engagement strategies and actions that the commissioner and responsible social services agencies may take to improve child welfare outcomes for African American children and their families;

(6) assist the commissioner with developing strategies for public messaging and communication related to racial disproportionality and disparities in child welfare outcomes for African American children and their families;

(7) assist the commissioner with identifying and developing internal and external partnerships to support adequate access to services and resources for African American children and their families, including but not limited to housing assistance, employment assistance, food and nutrition support, health care, child care assistance, and educational support and training; and

(8) assist the commissioner with developing strategies to promote the development of a culturally diverse and representative child welfare workforce in Minnesota that includes professionals who are reflective of the community served and who have been directly impacted by lived experiences within the child welfare system. The council must also assist the commissioner with exploring strategies and partnerships to address education and training needs, hiring, recruitment, retention, and professional advancement practices.

Sec. 11. Minnesota Statutes 2024, section 260.692, is amended to read:

260.692 AFRICAN AMERICAN CHILD AND FAMILY WELL-BEING UNIT.

Subdivision 1. **Duties.** The African American Child and Family Well-Being Unit, currently established by the commissioner, must:

(1) assist with the development of African American cultural competency training and review child welfare curriculum in the Minnesota Child Welfare Training Academy to ensure that responsible social services agency staff and other child welfare professionals are appropriately prepared to engage with African American children and their families and to support family preservation and reunification;

(2) provide technical assistance, including on-site technical assistance, and case consultation to responsible social services agencies to assist agencies with implementing and complying with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act;

(3) monitor individual county and statewide disaggregated and nondisaggregated data to identify trends and patterns in child welfare outcomes, including but not limited to reporting, maltreatment, out-of-home placement, and permanency of African American children and develop strategies to address disproportionality and disparities in the child welfare system;

(4) develop and implement a system for conducting case reviews when the commissioner receives reports of noncompliance with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act or when requested by the parent or custodian of an African American child. Case reviews may include but are not limited to a review of placement prevention efforts, safety planning, case planning and service provision by the responsible social services agency, relative placement consideration, and permanency planning;

(5) establish and administer a request for proposals process for African American and disproportionately represented family preservation grants under section 260.693, monitor grant activities, and provide technical assistance to grantees;

(6) in coordination with the African American Child and Family Well-Being Advisory Council, coordinate services and create internal and external partnerships to support adequate access to services and resources for African American children and their families, including but not limited to housing assistance, employment assistance, food and nutrition support, health care, child care assistance, and educational support and training; and

(7) develop public messaging and communication to inform the public about racial disparities in child welfare outcomes, current efforts and strategies to reduce racial disparities, and resources available to African American children and their families involved in the child welfare system.

Subd. 2. **Case reviews.** (a) The African American Child and Family Well-Being Unit must conduct systemic case reviews to monitor targeted child welfare outcomes, including but not limited to maltreatment, out-of-home placement, and permanency of African American children.

(b) The reviews under this subdivision must be conducted using a random sampling of representative child welfare cases stratified for certain case related factors, including but not limited to case type, maltreatment type, if the case involves out-of-home placement, and other demographic variables. In conducting the reviews, unit staff may use court records and documents, information from the social services information system, and other available case file information to complete the case reviews.

(c) The frequency of the reviews and the number of cases, child welfare outcomes, and selected counties reviewed shall be determined by the unit in consultation with the African American Child and Family Well-Being Advisory Council, with consideration given to the availability of unit resources needed to conduct the reviews.

(d) The unit must monitor all case reviews and use the collective case review information and data to generate summary case review reports, ensure compliance with the Minnesota African American Family Preservation and Child Welfare Disproportionality Act, and identify trends or patterns in child welfare outcomes for African American children.

(e) The unit must review information from members of the public received through the compliance and feedback portal, including policy and practice concerns related to individual child welfare cases. After assessing a case concern, the unit may determine if further necessary action should be taken, which may include coordinating case remediation with other relevant child welfare agencies in accordance with data privacy laws, including the African American Child and Family Well-Being Advisory Council, and offering case consultation and technical assistance to the responsible local social services agency as needed or requested by the agency.

Subd. 3. **Reports.** (a) The African American Child and Family Well-Being Unit must provide regular updates on unit activities, including summary reports of case reviews, to the African American Child and Family Well-Being Advisory Council, and must publish an annual census of African American children in out-of-home placements statewide. The annual census must include data on the types of placements, age and sex of the children, how long the children have been in out-of-home placements, and other relevant demographic information.

(b) The African American Child and Family Well-Being Unit shall gather summary data about the practice and policy inquiries and individual case concerns received through the compliance and feedback portal under subdivision 2, paragraph (e). The unit shall provide regular reports of the nonidentifying compliance and feedback portal summary data to the African American Child and Family Well-Being Advisory Council to identify child welfare trends and patterns to assist with developing policy and practice recommendations to support eliminating disparity and disproportionality for African American children.

Sec. 12. Minnesota Statutes 2024, section 260C.001, subdivision 2, is amended to read:

Subd. 2. **Juvenile protection proceedings.** (a) The paramount consideration in all juvenile protection proceedings is the health, safety, and best interests of the child. In proceedings involving an American Indian child, as defined in section 260.755, subdivision 8, the best interests of the child must be determined consistent with sections 260.751 to 260.835 and the Indian Child Welfare Act, United States Code, title 25, sections 1901 to 1923.

(b) The purpose of the laws relating to juvenile protection proceedings is:

(1) to secure for each child under the jurisdiction of the court, the care and guidance, preferably in the child's own home, as will best serve the spiritual, emotional, mental, and physical welfare of the child;

(2) to provide judicial procedures that protect the welfare of the child;

(3) to preserve and strengthen the child's family ties whenever possible and in the child's best interests, removing the child from the custody of parents only when the child's welfare or safety cannot be adequately safeguarded without removal;

(4) to ensure that when removal from the child's own family is necessary and in the child's best interests, the responsible social services agency has legal responsibility for the child removal either:

(i) pursuant to a voluntary placement agreement between the child's parent or guardian or the child, when the child is over age 18, and the responsible social services agency; or

(ii) by court order pursuant to section 260C.151, subdivision 6; 260C.178; 260C.201; 260C.325; or 260C.515;

(5) to ensure that, when placement is pursuant to court order, the court order removing the child or continuing the child in foster care contains an individualized determination that placement is in the best interests of the child that coincides with the actual removal of the child;

(6) to ensure that when the child is removed, the child's care and discipline is, as nearly as possible, equivalent to that which should have been given by the parents and is either in:

(i) the home of a noncustodial parent pursuant to section 260C.178 or 260C.201, subdivision 1, paragraph (a), clause (1);

(ii) the home of a relative pursuant to emergency placement by the responsible social services agency under chapter 245A; or

(iii) foster care licensed under chapter 245A; and

(7) to ensure appropriate permanency planning for children in foster care including:

(i) unless reunification is not required under section 260.012, developing a permanency plan for the child that includes a primary plan for reunification with the child's parent or guardian and a secondary plan for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner;

(ii) identifying, locating, and assessing both parents of the child as soon as possible and offering reunification services to both parents of the child as required under sections 260.012 and 260C.219;

(iii) inquiring about the child's heritage, including the child's Tribal lineage pursuant to section 260.761, and their race, culture, and ethnicity pursuant to section 260.63, subdivision 10;

~~(iii)~~ (iv) identifying, locating, and notifying relatives of both parents of the child according to section 260C.221;

~~(iv)~~ (v) making a placement with a family that will commit to being the legally permanent home for the child in the event reunification cannot occur at the earliest possible time while at the same time actively supporting the reunification plan; and

~~(v)~~ (vi) returning the child home with supports and services, as soon as return is safe for the child, or when safe return cannot be timely achieved, moving to finalize another legally permanent home for the child.

Sec. 13. Minnesota Statutes 2024, section 260C.007, subdivision 19, is amended to read:

Subd. 19. **Habitual truant.** "Habitual truant" means a child ~~under the age of 17~~ who is at least 12 years old and less than 18 years old who is absent from attendance at school without lawful excuse ~~for seven school days per school year if the child is in elementary school or~~ for one or more class periods on seven school days per school year if the child is in middle school, junior high school, or high school or a child who is 17 years of age who is absent from attendance at school without lawful excuse for one or more class periods on seven school days per school year and who has not lawfully withdrawn from school under section 120A.22, subdivision 8. Pursuant to section 260C.163, subdivision 11, habitual truant also means a child under age 12 who has been absent from school for seven school days without lawful excuse, based on a showing by clear and convincing evidence that the child's absence is not due to the failure of the child's parent, guardian, or custodian to comply with compulsory instruction laws.

Sec. 14. Minnesota Statutes 2024, section 260C.141, subdivision 1, is amended to read:

Subdivision 1. **Who may file; required form.** (a) Any reputable person, including but not limited to any agent of the commissioner of children, youth, and families, having knowledge of a child in this state or of a child who is a resident of this state, who appears to be in need of protection or services or neglected and in foster care, may petition the juvenile court in the manner provided in this section.

(b) A petition for a child in need of protection filed by an individual who is not a county attorney or an agent of the commissioner of children, youth, and families shall be filed on a form developed by the state court administrator and provided to court administrators. Copies of the form may be obtained from the court administrator in each county. The court administrator shall review the petition before it is filed to determine that it is completed. The court administrator may reject the petition if it does not indicate that the petitioner has contacted the responsible social services agency.

An individual may file a petition under this subdivision without seeking internal review of the responsible social services agency's decision. The court shall determine whether there is probable cause to believe that a need for protection or services exists before the matter is set for hearing. If the matter is set for hearing, the court administrator shall notify the responsible social services agency by sending notice to the county attorney.

The petition must contain:

(1) a statement of facts that would establish, if proven, that there is a need for protection or services for the child named in the petition;

(2) a statement that petitioner has reported the circumstances underlying the petition to the responsible social services agency, and protection or services were not provided to the child;

(3) a statement whether there are existing juvenile or family court custody orders or pending proceedings in juvenile or family court concerning the child; ~~and~~

(4) a statement of the relationship of the petitioner to the child and any other parties~~.~~; and

(5) a statement whether the petitioner has inquired of the parent or parents of the child, the child, and relatives about the child's heritage, including the child's Tribal lineage pursuant to section 260.761 and their race, culture, and ethnicity pursuant to section 260.63, subdivision 10.

The court may not allow a petition to proceed under this paragraph if it appears that the sole purpose of the petition is to modify custody between the parents.

Sec. 15. Minnesota Statutes 2024, section 260C.150, subdivision 3, is amended to read:

Subd. 3. **Identifying parents of child; diligent efforts; data.** (a) The responsible social services agency shall make diligent efforts to inquire about the child's heritage, including the child's Tribal lineage pursuant to section 260.761 and their race, culture, and ethnicity pursuant to section 260.63, subdivision 10, and to identify and locate both parents of any child who is the subject of proceedings under this chapter. Diligent efforts include:

(1) asking the custodial or known parent to identify any nonresident parent of the child and provide information that can be used to verify the nonresident parent's identity including the dates and locations of marriages and divorces; dates and locations of any legal proceedings regarding paternity; date and place of the child's birth; nonresident parent's full legal name; nonresident parent's date of birth, or if the nonresident parent's date of birth is unknown, an approximate age; the nonresident parent's Social Security number; the nonresident parent's whereabouts including last known whereabouts; and the whereabouts of relatives of the nonresident parent. For purposes of this subdivision, "nonresident parent" means a parent who does not reside in the same household as the child or did not reside in the same household as the child at the time the child was removed when the child is in foster care;

(2) obtaining information that will identify and locate the nonresident parent from the county and state of Minnesota child support enforcement information system;

(3) requesting a search of the Minnesota Fathers' Adoption Registry 30 days after the child's birth; and

(4) using any other reasonable means to identify and locate the nonresident parent.

(b) The agency may disclose data which is otherwise private under section 13.46 or chapter 260E in order to carry out its duties under this subdivision.

(c) Upon the filing of a petition alleging the child to be in need of protection or services, the responsible social services agency may contact a putative father who registered with the Minnesota Fathers' Adoption Registry more than 30 days after the child's birth. The social service agency may consider a putative father for the day-to-day care of the child under section 260C.219 if the putative father cooperates with genetic testing and there is a positive test result under section 257.62, subdivision 5. Nothing in this paragraph:

(1) relieves a putative father who registered with the Minnesota Fathers' Adoption Registry more than 30 days after the child's birth of the duty to cooperate with paternity establishment proceedings under section 260C.219;

(2) gives a putative father who registered with the Minnesota Fathers' Adoption Registry more than 30 days after the child's birth the right to notice under section 260C.151 unless the putative father is entitled to notice under sections 259.24 and 259.49, subdivision 1, paragraph (a) or (b), clauses (1) to (7); or

(3) establishes a right to assert an interest in the child in a termination of parental rights proceeding contrary to section 259.52, subdivision 6, unless the putative father is entitled to notice under sections 259.24 and 259.49, subdivision 1, paragraph (a) or (b), clauses (1) to (7).

Sec. 16. Minnesota Statutes 2024, section 260C.178, subdivision 1, is amended to read:

Subdivision 1. **Hearing and release requirements.** (a) If a child was taken into custody under section 260C.175, subdivision 1, clause (1) or (2), item (ii), the court shall hold a hearing within 72 hours of the time that the child was taken into custody, excluding Saturdays, Sundays, and holidays, to determine whether the child should continue to be in custody.

(b) Unless there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered, the child shall be released to the custody of a parent, guardian, custodian, or other suitable person, subject to reasonable conditions of release including, but not limited to, a requirement that the child undergo a chemical use assessment as provided in section 260C.157, subdivision 1.

(c) If the court determines that there is reason to believe that the child would endanger self or others or not return for a court hearing, or that the child's health or welfare would be immediately endangered if returned to the care of the parent or guardian who has custody and from whom the child was removed, the court shall order the child:

(1) into the care of the child's noncustodial parent and order the noncustodial parent to comply with any conditions that the court determines appropriate to ensure the safety and care of the child, including requiring the noncustodial parent to cooperate with paternity establishment proceedings if the noncustodial parent has not been adjudicated the child's father; or

(2) into foster care as defined in section 260C.007, subdivision 18, under the legal responsibility of the responsible social services agency or responsible probation or corrections agency for the purposes of protective care as that term is used in the juvenile court rules. The court shall not give the responsible social services legal custody and order a trial home visit at any time prior to adjudication and disposition under section 260C.201, subdivision 1, paragraph (a), clause (3), but may order the child returned to the care of the parent or guardian who has custody and from whom the child was removed and order the parent or guardian to comply with any conditions the court determines to be appropriate to meet the safety, health, and welfare of the child.

(d) In determining whether the child's health or welfare would be immediately endangered, the court shall consider whether the child would reside with a perpetrator of domestic child abuse.

(e) The court, before determining whether a child should be placed in or continue in foster care under the protective care of the responsible agency, shall also make a determination, consistent with section 260.012 as to whether reasonable efforts were made to prevent placement or whether reasonable efforts to prevent placement are not required. In the case of an Indian child, the court shall determine whether active efforts, according to section 260.762 and the Indian Child Welfare Act of 1978, United States Code, title 25, section 1912(d), were made to prevent placement. The court shall enter a finding that the responsible social services agency has made reasonable efforts to prevent placement when the agency establishes either:

(1) that the agency has actually provided services or made efforts in an attempt to prevent the child's removal but that such services or efforts have not proven sufficient to permit the child to safely remain in the home; or

(2) that there are no services or other efforts that could be made at the time of the hearing that could safely permit the child to remain home or to return home. The court shall not make a reasonable efforts determination under this clause unless the court is satisfied that the agency has sufficiently demonstrated to the court that there were no services or other efforts that the agency was able to provide at the time of the hearing enabling the child to safely remain home or to safely return home. When reasonable efforts to prevent placement are required and there are services or other efforts that could be ordered that would permit the child to safely return home, the court shall order the child returned to the care of the parent or guardian and the services or efforts put in place to ensure the child's safety. When the court makes a prima facie determination that one of the circumstances under paragraph (g) exists, the court shall determine that reasonable efforts to prevent placement and to return the child to the care of the parent or guardian are not required.

(f) If the court finds the social services agency's preventive or reunification efforts have not been reasonable but further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(g) The court may not order or continue the foster care placement of the child unless the court makes explicit, individualized findings that continued custody of the child by the parent or guardian would be contrary to the welfare of the child and that placement is in the best interest of the child.

(h) At the emergency removal hearing, or at any time during the course of the proceeding, and upon notice and request of the county attorney, the court shall determine whether a petition has been filed stating a prima facie case that:

(1) the parent has subjected a child to egregious harm as defined in section 260C.007, subdivision 14;

(2) the parental rights of the parent to another child have been involuntarily terminated;

(3) the child is an abandoned infant under section 260C.301, subdivision 2, paragraph (a), clause (2);

(4) the parents' custodial rights to another child have been involuntarily transferred to a relative under a juvenile protection proceeding or a similar process of another jurisdiction;

(5) the parent has committed sexual abuse as defined in section 260E.03, against the child or another child of the parent;

(6) the parent has committed an offense that requires registration as a predatory offender under section 243.166, subdivision 1b, paragraph (a) or (b); or

(7) the provision of services or further services for the purpose of reunification is futile and therefore unreasonable.

(i) When a petition to terminate parental rights is required under section 260C.301, subdivision 4, or 260C.503, subdivision 2, but the county attorney has determined not to proceed with a termination of parental rights petition, and has instead filed a petition to transfer permanent legal and physical custody to a relative under section 260C.507, the court shall schedule a permanency hearing within 30 days of the filing of the petition.

(j) If the county attorney has filed a petition under section 260C.307, the court shall schedule a trial under section 260C.163 within 90 days of the filing of the petition except when the county attorney determines that the criminal case shall proceed to trial first under section 260C.503, subdivision 2, paragraph (c).

(k) If the court determines the child should be ordered into foster care ~~and~~, the court shall inquire about the child's heritage, including the child's Tribal lineage pursuant to section 260.761; their race, culture, and ethnicity pursuant to section 260.63, subdivision 10; and the responsible social services agency's initial relative search efforts. If the child's parent refuses to give information to the responsible social services agency regarding the child's father or relatives of the child, the court may order the parent to disclose the names, addresses, telephone numbers, and other identifying information to the responsible social services agency for the purpose of complying with sections 260C.150, 260C.151, 260C.212, 260C.215, 260C.219, and 260C.221.

(l) If a child ordered into foster care has siblings, whether full, half, or step, who are also ordered into foster care, the court shall inquire of the responsible social services agency of the efforts to place the children together as required by section 260C.212, subdivision 2, paragraph (d), if placement together is in each child's best interests, unless a child is in placement for treatment or a child is placed with a previously noncustodial parent who is not a parent to all siblings. If the children are not placed together at the time of the hearing, the court shall inquire at each subsequent hearing of the agency's reasonable efforts to place the siblings together, as required under section 260.012. If any sibling is not placed with another sibling or siblings, the agency must develop a plan to facilitate visitation or ongoing contact among the siblings as required under section 260C.212, subdivision 1, unless it is contrary to the safety or well-being of any of the siblings to do so.

(m) When the court has ordered the child into the care of a noncustodial parent or in foster care, the court may order a chemical dependency evaluation, mental health evaluation, medical examination, and parenting assessment for the parent as necessary to support the development of a plan for reunification required under subdivision 7 and section 260C.212, subdivision 1, or the child protective services plan under section 260E.26, and Minnesota Rules, part 9560.0228.

(n) When the court has ordered an Indian child into an emergency child placement, the Indian child shall be placed according to the placement preferences in the Minnesota Indian Family Preservation Act, section 260.773.

Sec. 17. Minnesota Statutes 2024, section 260C.178, subdivision 7, is amended to read:

Subd. 7. **Case plan.** (a) When the court has ordered the child into the care of a parent under subdivision 1, paragraph (c), clause (1), the child protective services plan under section 260E.26 must be filed within 30 days of the filing of the juvenile protection petition under section 260C.141, subdivision 1.

(b) When the court orders the child into foster care under subdivision 1, paragraph (c), clause (2), and not into the care of a parent, an out-of-home placement plan summary required under section 260C.212, subdivision 1, must be filed with the court within 30 days of the filing of a juvenile protection petition under section 260C.141, subdivision 1, when the court orders emergency removal of the child under this section, or filed with the petition if the petition is a review of a voluntary placement under section 260C.141, subdivision 2. An out-of-home placement plan shall be prepared and filed with the court within 60 days after any child is placed in foster care under section 260C.212, subdivision 1.

(c) Upon the filing of the child protective services plan under section 260E.26 or out-of-home placement plan that has been developed jointly with the parent and in consultation with others as required under section 260C.212, subdivision 1, the court may approve implementation of the plan by the responsible social services agency based on the allegations contained in the petition and any evaluations, examinations, or assessments conducted under subdivision 1, paragraph (m). The court shall send written notice of the approval of the child protective services plan or out-of-home placement plan to all parties and the county attorney or may state such approval on the record at a hearing. A parent may agree to comply with the terms of the plan filed with the court.

(d) The responsible social services agency shall make reasonable efforts to engage both parents of the child in case planning. The responsible social services agency shall report the results of its efforts to engage the child's parents in the child protective services plan or out-of-home placement plan filed with the court. The agency shall notify the court of the services it will provide or efforts it will attempt under the plan notwithstanding the parent's refusal to cooperate or disagreement with the services. The parent may ask the court to modify the plan to require different or additional services requested by the parent, but which the agency refused to provide. The court may approve the plan as presented by the agency or may modify the plan to require services requested by the parent. The court's approval must be based on the content of the petition.

(e) Unless the parent agrees to comply with the terms of the child protective services plan or out-of-home placement plan, the court may not order a parent to comply with the provisions of the plan until the court finds the child is in need of protection or services and orders disposition under section 260C.201, subdivision 1. However, the court may find that the responsible social services agency has made reasonable efforts for reunification if the agency makes efforts to implement the terms of the child protective services plan or out-of-home placement plan approved under this section.

Sec. 18. Minnesota Statutes 2024, section 260C.201, subdivision 1, is amended to read:

Subdivision 1. **Dispositions.** (a) If the court finds that the child is in need of protection or services or neglected and in foster care, the court shall enter an order making any of the following dispositions of the case:

(1) place the child under the protective supervision of the responsible social services agency or child-placing agency in the home of a parent of the child under conditions prescribed by the court directed to the correction of the child's need for protection or services:

(i) the court may order the child into the home of a parent who does not otherwise have legal custody of the child, however, an order under this section does not confer legal custody on that parent;

(ii) if the court orders the child into the home of a father who is not adjudicated, the father must cooperate with paternity establishment proceedings regarding the child in the appropriate jurisdiction as one of the conditions prescribed by the court for the child to continue in the father's home; and

(iii) the court may order the child into the home of a noncustodial parent with conditions and may also order both the noncustodial and the custodial parent to comply with the requirements of a case plan under subdivision 2; ~~or~~

(2) transfer legal custody to one of the following:

(i) a child-placing agency; or

(ii) the responsible social services agency. In making a foster care placement of a child whose custody has been transferred under this subdivision, the court shall inquire about the child's heritage, including the child's Tribal lineage pursuant to section 260.761 and their race, culture, and ethnicity pursuant to section 260.63, subdivision 10, and the agency shall make an individualized determination of how the placement is in the child's best interests using

the placement consideration order for relatives and the best interest factors in section 260C.212, subdivision 2, and may include a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190; ~~or~~

(3) order a trial home visit without modifying the transfer of legal custody to the responsible social services agency under clause (2). Trial home visit means the child is returned to the care of the parent or guardian from whom the child was removed for a period not to exceed six months. During the period of the trial home visit, the responsible social services agency:

(i) shall continue to have legal custody of the child, which means that the agency may see the child in the parent's home, at school, in a child care facility, or other setting as the agency deems necessary and appropriate;

(ii) shall continue to have the ability to access information under section 260C.208;

(iii) shall continue to provide appropriate services to both the parent and the child during the period of the trial home visit;

(iv) without previous court order or authorization, may terminate the trial home visit in order to protect the child's health, safety, or welfare and may remove the child to foster care;

(v) shall advise the court and parties within three days of the termination of the trial home visit when a visit is terminated by the responsible social services agency without a court order; and

(vi) shall prepare a report for the court when the trial home visit is terminated whether by the agency or court order that describes the child's circumstances during the trial home visit and recommends appropriate orders, if any, for the court to enter to provide for the child's safety and stability. In the event a trial home visit is terminated by the agency by removing the child to foster care without prior court order or authorization, the court shall conduct a hearing within ten days of receiving notice of the termination of the trial home visit by the agency and shall order disposition under this subdivision or commence permanency proceedings under sections 260C.503 to 260C.515. The time period for the hearing may be extended by the court for good cause shown and if it is in the best interests of the child as long as the total time the child spends in foster care without a permanency hearing does not exceed 12 months;

(4) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a physical or mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the court may order the child's parent, guardian, or custodian to provide it. The court may order the child's health plan company to provide mental health services to the child. Section 62Q.535 applies to an order for mental health services directed to the child's health plan company. If the health plan, parent, guardian, or custodian fails or is unable to provide this treatment or care, the court may order it provided. Absent specific written findings by the court that the child's disability is the result of abuse or neglect by the child's parent or guardian, the court shall not transfer legal custody of the child for the purpose of obtaining special treatment or care solely because the parent is unable to provide the treatment or care. If the court's order for mental health treatment is based on a diagnosis made by a treatment professional, the court may order that the diagnosing professional not provide the treatment to the child if it finds that such an order is in the child's best interests; or

(5) if the court believes that the child has sufficient maturity and judgment and that it is in the best interests of the child, the court may order a child 16 years old or older to be allowed to live independently, either alone or with others as approved by the court under supervision the court considers appropriate, if the county board, after consultation with the court, has specifically authorized this dispositional alternative for a child.

(b) If the child was adjudicated in need of protection or services because the child is a runaway or habitual truant, the court may order any of the following dispositions in addition to or as alternatives to the dispositions authorized under paragraph (a):

(1) counsel the child or the child's parents, guardian, or custodian;

(2) place the child under the supervision of a probation officer or other suitable person in the child's own home under conditions prescribed by the court, including reasonable rules for the child's conduct and the conduct of the parents, guardian, or custodian, designed for the physical, mental, and moral well-being and behavior of the child;

(3) subject to the court's supervision, transfer legal custody of the child to one of the following:

(i) a reputable person of good moral character. No person may receive custody of two or more unrelated children unless licensed to operate a residential program under sections 245A.01 to 245A.16; or

(ii) a county probation officer for placement in a group foster home established under the direction of the juvenile court and licensed pursuant to section 241.021;

(4) require the child to pay a fine of up to $100. The court shall order payment of the fine in a manner that will not impose undue financial hardship upon the child;

(5) require the child to participate in a community service project;

(6) order the child to undergo a chemical dependency evaluation and, if warranted by the evaluation, order participation by the child in a drug awareness program or an inpatient or outpatient chemical dependency treatment program;

(7) if the court believes that it is in the best interests of the child or of public safety that the child's driver's license or instruction permit be canceled, the court may order the commissioner of public safety to cancel the child's license or permit for any period up to the child's 18th birthday. If the child does not have a driver's license or permit, the court may order a denial of driving privileges for any period up to the child's 18th birthday. The court shall forward an order issued under this clause to the commissioner, who shall cancel the license or permit or deny driving privileges without a hearing for the period specified by the court. At any time before the expiration of the period of cancellation or denial, the court may, for good cause, order the commissioner of public safety to allow the child to apply for a license or permit, and the commissioner shall so authorize;

(8) order that the child's parent or legal guardian deliver the child to school at the beginning of each school day for a period of time specified by the court; or

(9) require the child to perform any other activities or participate in any other treatment programs deemed appropriate by the court.

To the extent practicable, the court shall enter a disposition order the same day it makes a finding that a child is in need of protection or services or neglected and in foster care, but in no event more than 15 days after the finding unless the court finds that the best interests of the child will be served by granting a delay. If the child was under eight years of age at the time the petition was filed, the disposition order must be entered within ten days of the finding and the court may not grant a delay unless good cause is shown and the court finds the best interests of the child will be served by the delay.

(c) If a child who is 14 years of age or older is adjudicated in need of protection or services because the child is a habitual truant and truancy procedures involving the child were previously dealt with by a school attendance review board or county attorney mediation program under section 260A.06 or 260A.07, the court shall order a cancellation or denial of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th birthday.

(d) In the case of a child adjudicated in need of protection or services because the child has committed domestic abuse and been ordered excluded from the child's parent's home, the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing to provide an alternative safe living arrangement for the child as defined in paragraph (f).

(e) When a parent has complied with a case plan ordered under subdivision 6 and the child is in the care of the parent, the court may order the responsible social services agency to monitor the parent's continued ability to maintain the child safely in the home under such terms and conditions as the court determines appropriate under the circumstances.

(f) For the purposes of this subdivision, "alternative safe living arrangement" means a living arrangement for a child proposed by a petitioning parent or guardian if a court excludes the minor from the parent's or guardian's home that is separate from the victim of domestic abuse and safe for the child respondent. A living arrangement proposed by a petitioning parent or guardian is presumed to be an alternative safe living arrangement absent information to the contrary presented to the court. In evaluating any proposed living arrangement, the court shall consider whether the arrangement provides the child with necessary food, clothing, shelter, and education in a safe environment. Any proposed living arrangement that would place the child in the care of an adult who has been physically or sexually violent is presumed unsafe.

Sec. 19. Minnesota Statutes 2024, section 260C.201, subdivision 2, is amended to read:

Subd. 2. **Written findings.** (a) Any order for a disposition authorized under this section shall contain written findings of fact to support the disposition and case plan ordered and shall also set forth in writing the following information:

(1) why the best interests and safety of the child are served by the disposition and case plan ordered;

(2) what alternative dispositions or services under the case plan were considered by the court and why such dispositions or services were not appropriate in the instant case;

(3) when legal custody of the child is transferred, the appropriateness of the particular placement made or to be made by the placing agency using the relative and sibling placement considerations and best interest factors in section 260C.212, subdivision 2, or the appropriateness of a child colocated with a parent in a licensed residential family-based substance use disorder treatment program under section 260C.190;

(4) whether reasonable efforts to finalize the permanent plan for the child consistent with section 260.012 were made including reasonable efforts:

(i) to prevent the child's placement and to reunify the child with the parent or guardian from whom the child was removed at the earliest time consistent with the child's safety. The court's findings must include a brief description of what preventive and reunification efforts were made and why further efforts could not have prevented or eliminated the necessity of removal or that reasonable efforts were not required under section 260.012 or 260C.178, subdivision 1;

(ii) to identify and locate any noncustodial or nonresident parent of the child and to assess such parent's ability to provide day-to-day care of the child, and, where appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide day-to-day care of the child as required under section 260C.219, unless such services are not required under section 260.012 or 260C.178, subdivision 1. The court's findings must include a description of the agency's efforts to:

(A) identify and locate the child's noncustodial or nonresident parent;

(B) assess the noncustodial or nonresident parent's ability to provide day-to-day care of the child; and

(C) if appropriate, provide services necessary to enable the noncustodial or nonresident parent to safely provide the child's day-to-day care, including efforts to engage the noncustodial or nonresident parent in assuming care and responsibility of the child;

(iii) to inquire about the child's heritage, including the child's Tribal lineage pursuant to section 260.761 and their race, culture, and ethnicity pursuant to section 260.63, subdivision 10, and make the diligent search for relatives and provide the notices required under section 260C.221; a finding made pursuant to a hearing under section 260C.202 that the agency has made diligent efforts to conduct a relative search and has appropriately engaged relatives who responded to the notice under section 260C.221 and other relatives, who came to the attention of the agency after notice under section 260C.221 was sent, in placement and case planning decisions fulfills the requirement of this item;

(iv) to identify and make a foster care placement of the child, considering the order in section 260C.212, subdivision 2, paragraph (a), in the home of an unlicensed relative, according to the requirements of section 142B.06, a licensed relative, or other licensed foster care provider, who will commit to being the permanent legal parent or custodian for the child in the event reunification cannot occur, but who will actively support the reunification plan for the child. If the court finds that the agency has not appropriately considered relatives for placement of the child, the court shall order the agency to comply with section 260C.212, subdivision 2, paragraph (a). The court may order the agency to continue considering relatives for placement of the child regardless of the child's current placement setting; and

(v) to place siblings together in the same home or to ensure visitation is occurring when siblings are separated in foster care placement and visitation is in the siblings' best interests under section 260C.212, subdivision 2, paragraph (d); and

(5) if the child has been adjudicated as a child in need of protection or services because the child is in need of special services or care to treat or ameliorate a mental disability or emotional disturbance as defined in section 245.4871, subdivision 15, the written findings shall also set forth:

(i) whether the child has mental health needs that must be addressed by the case plan;

(ii) what consideration was given to the diagnostic and functional assessments performed by the child's mental health professional and to health and mental health care professionals' treatment recommendations;

(iii) what consideration was given to the requests or preferences of the child's parent or guardian with regard to the child's interventions, services, or treatment; and

(iv) what consideration was given to the cultural appropriateness of the child's treatment or services.

(b) If the court finds that the social services agency's preventive or reunification efforts have not been reasonable but that further preventive or reunification efforts could not permit the child to safely remain at home, the court may nevertheless authorize or continue the removal of the child.

(c) If the child has been identified by the responsible social services agency as the subject of concurrent permanency planning, the court shall review the reasonable efforts of the agency to develop a permanency plan for the child that includes a primary plan that is for reunification with the child's parent or guardian and a secondary plan that is for an alternative, legally permanent home for the child in the event reunification cannot be achieved in a timely manner.

Sec. 20. Minnesota Statutes 2024, section 260C.202, subdivision 2, is amended to read:

Subd. 2. **Court review for a child placed in foster care.** (a) If the court orders a child placed in foster care, the court shall review the out-of-home placement plan and the child's placement at least every 90 days as required in juvenile court rules to determine whether continued out-of-home placement is necessary and appropriate or whether the child should be returned home.

(b) This review is not required if the court has returned the child home, ordered the child permanently placed away from the parent under sections 260C.503 to 260C.521, or terminated rights under section 260C.301. Court review for a child permanently placed away from a parent, including where the child is under guardianship of the commissioner, is governed by section 260C.607.

(c) When a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

(d) No later than three months after the child's placement in foster care, the court shall review agency efforts to search for and notify relatives pursuant to section 260C.221, and order that the agency's efforts begin immediately, or continue, if the agency has failed to perform, or has not adequately performed, the duties under that section. The court must order the agency to continue to appropriately engage relatives who responded to the notice under section 260C.221 in placement and case planning decisions and to consider relatives for foster care placement consistent with section 260C.221. Notwithstanding a court's finding that the agency has made reasonable efforts to search for and notify relatives under section 260C.221, the court may order the agency to continue making reasonable efforts to search for, notify, engage, and consider relatives who came to the agency's attention after sending the initial notice under section 260C.221.

(e) The court shall review the out-of-home placement plan and may modify the plan as provided under section 260C.201, subdivisions 6 and 7.

(f) When the court transfers the custody of a child to a responsible social services agency resulting in foster care or protective supervision with a noncustodial parent under subdivision 1, the court shall notify the parents of the provisions of sections 260C.204 and 260C.503 to 260C.521, as required under juvenile court rules.

~~(g) When a child remains in or returns to foster care pursuant to section 260C.451 and the court has jurisdiction pursuant to section 260C.193, subdivision 6, paragraph (c), the court shall at least annually conduct the review required under section 260C.203.~~

Sec. 21. Minnesota Statutes 2024, section 260C.202, is amended by adding a subdivision to read:

Subd. 3. **Court review prior to the 18th birthday of a child in foster care.** (a) The court must conduct a review during the 90-day period prior to the 18th birthday of a child in foster care.

(b) The responsible social services agency must file a written report with the court containing or attaching the following:

(1) the child's name, date of birth, race, gender, and current address;

(2) whether the child is eligible for extended foster care and if not, the reason or reasons why the child is not eligible;

(3) a written summary describing how the child was involved in creating the child's plan for after their 18th birthday;

(4) the date the required extended foster care eligibility notice in section 260C.451, subdivision 1, was provided and the child's plan after the child's 18th birthday;

(5) the child's most recent independent living plan required under section 260C.212, subdivision 1;

(6) if the agency's recommendation is to extend jurisdiction up to age 19 under section 260C.193, why the extended jurisdiction is in the child's best interest;

(7) if the agency's recommendation is to reunify the child with their parent or legal guardian, why reunification is in the child's best interest;

(8) if the agency plans to transition the child into adult services on or after the child's 18th birthday, a summary of the transition plan as required in section 260C.452 and how this plan is in the child's best interest; and

(9) if the child's plan is to leave foster care at age 18 and not continue in extended foster care, a copy of their 180-day transition plan required in section 260C.452 and the reasons the child is not continuing in extended foster care.

(c) The agency must inform the child and parties to the proceeding of the reporting and court review requirements of this subdivision and their right to request a hearing. The child or a party to the proceeding may request a hearing if they believe the agency did not make reasonable efforts under this subdivision.

(d) Upon receiving the report, the court must hold a hearing when a party to the proceeding or the child requests a hearing. In all other circumstances, the court has the discretion to hold a hearing or issue an order without a hearing.

(e) The court must issue an order with findings including but not limited to the following:

(1) whether the responsible social services agency provided the notice to the child about extended foster care as required in section 260C.451;

(2) whether the responsible social services agency engaged with the child and appropriately planned with the child to transition to adulthood; and

(3) if the child has decided to not continue in the extended foster care program at age 18, whether the responsible social services agency informed the child that they can reenter extended foster care up to age 21 or that the child is not eligible to reenter and why.

Sec. 22. Minnesota Statutes 2024, section 260C.202, is amended by adding a subdivision to read:

Subd. 4. **Court reviews for a child over age 18 in foster care.** When a child remains in or returns to foster care pursuant to section 260C.451 and the court has jurisdiction pursuant to section 260C.193, subdivision 6, paragraph (c), the court must at least annually conduct the review required under section 260C.203.

Sec. 23. Minnesota Statutes 2024, section 260C.204, is amended to read:

260C.204 PERMANENCY PROGRESS REVIEW FOR CHILDREN IN FOSTER CARE FOR SIX MONTHS.

(a) When a child continues in placement out of the home of the parent or guardian from whom the child was removed, no later than six months after the child's placement the court shall conduct a permanency progress hearing to review:

(1) the progress of the case, the parent's progress on the case plan or out-of-home placement plan, whichever is applicable;

(2) the agency's reasonable, or in the case of an Indian child, active efforts for reunification and its provision of services;

(3) the agency's reasonable efforts to finalize the permanent plan for the child under section 260.012, paragraph (e), and to make a placement as required under section 260C.212, subdivision 2, in a home that will commit to being the legally permanent family for the child in the event the child cannot return home according to the timelines in this section; and

(4) in the case of an Indian child, active efforts to prevent the breakup of the Indian family and to make a placement according to the placement preferences under United States Code, title 25, chapter 21, section 1915.

(b) When a child is placed in a qualified residential treatment program setting as defined in section 260C.007, subdivision 26d, the responsible social services agency must submit evidence to the court as specified in section 260C.712.

(c) The court shall ensure that notice of the hearing is sent to any relative who:

(1) responded to the agency's notice provided under section 260C.221, indicating an interest in participating in planning for the child or being a permanency resource for the child and who has kept the court apprised of the relative's address; or

(2) asked to be notified of court proceedings regarding the child as is permitted in section 260C.152, subdivision 5.

(d)(1) If the parent or guardian has maintained contact with the child and is complying with the court-ordered out-of-home placement plan, and if the child would benefit from reunification with the parent, the court may either:

(i) return the child home, if the conditions that led to the out-of-home placement have been sufficiently mitigated that it is safe and in the child's best interests to return home; or

(ii) continue the matter up to a total of six additional months. If the child has not returned home by the end of the additional six months, the court must conduct a hearing according to sections 260C.503 to 260C.521.

(2) If the court determines that the parent or guardian is not complying, is not making progress with or engaging with services in the out-of-home placement plan, or is not maintaining regular contact with the child as outlined in the visitation plan required as part of the out-of-home placement plan under section 260C.212, the court may order the responsible social services agency:

(i) to develop a plan for legally permanent placement of the child away from the parent;

(ii) to consider, identify, recruit, and support one or more permanency resources from the child's relatives and foster parent, consistent with clause (3) and section 260C.212, subdivision 2, paragraph (a), to be the legally permanent home in the event the child cannot be returned to the parent. Any relative or the child's foster parent may ask the court to order the agency to consider them for permanent placement of the child in the event the child cannot be returned to the parent. A relative or foster parent who wants to be considered under this item shall cooperate with the background study required under section 245C.08, if the individual has not already done so, and with the home study process required under chapter 142B for providing child foster care and for adoption under section 259.41. The home study referred to in this item shall be a single-home study in the form required by the commissioner of children, youth, and families or similar study required by the individual's state of residence when the subject of the study is not a resident of Minnesota. The court may order the responsible social services agency to make a referral under the Interstate Compact on the Placement of Children when necessary to obtain a home study for an individual who wants to be considered for transfer of permanent legal and physical custody or adoption of the child; and

(iii) to file a petition to support an order for the legally permanent placement plan.

(3) Consistent with section 260C.223, subdivision 2, paragraph (b), the responsible social services agency must not define a foster family as the permanent home for a child until:

(i) inquiry and Tribal notice requirements under section 260.761, subdivisions 1 and 2, are satisfied;

(ii) inquiry about the child's heritage, including their race, culture, and ethnicity pursuant to section 260.63, subdivision 10, has been completed; and

(iii) the court has determined that reasonable or active efforts toward completing the relative search requirements in section 260C.221 have been made.

(e) Following the review under this section:

(1) if the court has either returned the child home or continued the matter up to a total of six additional months, the agency shall continue to provide services to support the child's return home or to make reasonable efforts to achieve reunification of the child and the parent as ordered by the court under an approved case plan;

(2) if the court orders the agency to develop a plan for the transfer of permanent legal and physical custody of the child to a relative, a petition supporting the plan shall be filed in juvenile court within 30 days of the hearing required under this section and a trial on the petition held within 60 days of the filing of the pleadings; or

(3) if the court orders the agency to file a termination of parental rights, unless the county attorney can show cause why a termination of parental rights petition should not be filed, a petition for termination of parental rights shall be filed in juvenile court within 30 days of the hearing required under this section and a trial on the petition held within 60 days of the filing of the petition.

Sec. 24. Minnesota Statutes 2024, section 260C.212, subdivision 1, is amended to read:

Subdivision 1. **Out-of-home placement; plan.** ~~(a) An out-of-home placement plan shall be prepared within 30 days after any child is placed in foster care by court order or a voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D.~~

~~(b)~~ (a) An out-of-home placement plan means a written document individualized to the needs of the child and the child's parents or guardians that is prepared by the responsible social services agency using a form developed by the commissioner. The plan must be completed jointly with the child's parents or guardians and in consultation with the child's guardian ad litem; the child's tribe, if the child is an Indian child; the child's foster parent or representative of

the foster care facility; and, when appropriate, the child. When a child is age 14 or older, the child may include two other individuals on the team preparing the child's out-of-home placement plan. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards. The responsible social services agency may reject an individual selected by the child if the agency has good cause to believe that the individual would not act in the best interest of the child. For a child in voluntary foster care for treatment under chapter 260D, preparation of the out-of-home placement plan shall additionally include the child's mental health treatment provider. For a child 18 years of age or older, the responsible social services agency shall involve the child and the child's parents as appropriate. As appropriate, the plan shall be:

(1) submitted to the court for approval under section 260C.178, subdivision 7;

(2) ordered by the court, either as presented or modified after hearing, under section 260C.178, subdivision 7, or 260C.201, subdivision 6; and

(3) signed by the parent or parents or guardian of the child, the child's guardian ad litem, a representative of the child's tribe, the responsible social services agency, and, if possible, the child.

(b) Before an out-of-home placement plan is signed by the parent or parents or guardian of the child, the responsible social services agency must provide the parent or parents or guardian with a one- to two-page summary of the plan using a form developed by the commissioner. The out-of-home placement plan summary must clearly summarize the plan's contents under paragraph (d) and list the requirements and responsibilities for the parent or parents or guardian using plain language. The summary must be updated and provided to the parent or parents or guardian when the out-of-home placement plan is updated under subdivision 1a.

(c) An out-of-home placement plan summary shall be prepared within 30 days after any child is placed in foster care by court order or voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D. An out-of-home placement plan shall be prepared within 60 days after any child is placed in foster care by court order or a voluntary placement agreement between the responsible social services agency and the child's parent pursuant to section 260C.227 or chapter 260D.

~~(c)~~ (d) The out-of-home placement plan shall be explained by the responsible social services agency to all persons involved in the plan's implementation, including the child who has signed the plan, and shall set forth:

(1) a description of the foster care home or facility selected, including how the out-of-home placement plan is designed to achieve a safe placement for the child in the least restrictive, most family-like setting available that is in close proximity to the home of the child's parents or guardians when the case plan goal is reunification; and how the placement is consistent with the best interests and special needs of the child according to the factors under subdivision 2, paragraph (b);

(2) a description of the services offered and provided to prevent removal of the child from the home;

~~(2)~~ (3) the specific reasons for the placement of the child in foster care, and when reunification is the plan, a description of the problems or conditions in the home of the parent or parents that necessitated removal of the child from home and the services offered and provided to support the changes the parent or parents must make for the child to safely return home~~;~~

~~(3) a description of the services offered and provided to prevent removal of the child from the home~~ and to reunify the family including:

(i) the specific actions to be taken by the parent or parents of the child to eliminate or correct the problems or conditions identified in clause (2), and the time period during which the actions are to be taken; and

(ii) the reasonable efforts, or in the case of an Indian child, active efforts to be made to achieve a safe and stable home for the child including social and other supportive services to be provided or offered to the parent or parents or guardian of the child, the child, and the residential facility during the period the child is in the residential facility;

(4) a description of any services or resources that were requested by the child or the child's parent, guardian, foster parent, or custodian since the date of the child's placement in the residential facility, and whether those services or resources were provided and if not, the basis for the denial of the services or resources;

(5) the visitation plan for the parent or parents or guardian, other relatives as defined in section 260C.007, subdivision 26b or 27, and siblings of the child if the siblings are not placed together in foster care, and whether visitation is consistent with the best interest of the child, during the period the child is in foster care;

(6) when a child cannot return to or be in the care of either parent, documentation of steps to finalize permanency through either:

(i) adoption as the permanency plan for the child through reasonable efforts to place the child for adoption pursuant to section 260C.605. At a minimum, the documentation must include consideration of whether adoption is in the best interests of the child and child-specific recruitment efforts such as a relative search, consideration of relatives for adoptive placement, and the use of state, regional, and national adoption exchanges to facilitate orderly and timely placements in and outside of the state. A copy of this documentation shall be provided to the court in the review required under section 260C.317, subdivision 3, paragraph (b); or

~~(7) when a child cannot return to or be in the care of either parent, documentation of steps to finalize~~ (ii) the transfer of permanent legal and physical custody to a relative as the permanency plan for the child. This documentation must support the requirements of the kinship placement agreement under section 142A.605 and must include the reasonable efforts used to determine that it is not appropriate for the child to return home or be adopted, and reasons why permanent placement with a relative through a Northstar kinship assistance arrangement is in the child's best interest; how the child meets the eligibility requirements for Northstar kinship assistance payments; agency efforts to discuss adoption with the child's relative foster parent and reasons why the relative foster parent chose not to pursue adoption, if applicable; and agency efforts to discuss with the child's parent or parents the permanent transfer of permanent legal and physical custody or the reasons why these efforts were not made;

~~(8)~~ (7) efforts to ensure the child's educational stability while in foster care for a child who attained the minimum age for compulsory school attendance under state law and is enrolled full time in elementary or secondary school, or instructed in elementary or secondary education at home, or instructed in an independent study elementary or secondary program, or incapable of attending school on a full-time basis due to a medical condition that is documented and supported by regularly updated information in the child's case plan. Educational stability efforts include:

(i) efforts to ensure that the child remains in the same school in which the child was enrolled prior to placement or upon the child's move from one placement to another, including efforts to work with the local education authorities to ensure the child's educational stability and attendance; or

(ii) if it is not in the child's best interest to remain in the same school that the child was enrolled in prior to placement or move from one placement to another, efforts to ensure immediate and appropriate enrollment for the child in a new school;

~~(9)~~ (8) the educational records of the child including the most recent information available regarding:

(i) the names and addresses of the child's educational providers;

(ii) the child's grade level performance;

(iii) the child's school record;

(iv) a statement about how the child's placement in foster care takes into account proximity to the school in which the child is enrolled at the time of placement; and

(v) any other relevant educational information;

~~(10)~~ (9) the efforts by the responsible social services agency to ~~ensure~~ support the child's well-being by ensuring the oversight and continuity of health care services for the foster child and documenting their health record, including:

(i) the plan to schedule the child's initial health screens;

(ii) how the child's known medical problems and identified needs from the screens, including any known communicable diseases, as defined in section 144.4172, subdivision 2, shall be monitored and treated while the child is in foster care;

(iii) how the child's medical information shall be updated and shared, including the child's immunizations;

(iv) who is responsible to coordinate and respond to the child's health care needs, including the role of the parent, the agency, and the foster parent;

(v) who is responsible for oversight of the child's prescription medications;

(vi) how physicians or other appropriate medical and nonmedical professionals shall be consulted and involved in assessing the health and well-being of the child and determine the appropriate medical treatment for the child; ~~and~~

(vii) the responsibility to ensure that the child has access to medical care through either medical insurance or medical assistance; and

~~(11) the health records of the child including~~ (viii) information available regarding:

~~(i)~~ (A) the names and addresses of the child's health care and dental care providers;

~~(ii)~~ (B) a record of the child's immunizations;

~~(iii)~~ (C) the child's known medical problems, including any known communicable diseases as defined in section 144.4172, subdivision 2;

~~(iv)~~ (D) the child's medications; and

~~(v)~~ (E) any other relevant health care information such as the child's eligibility for medical insurance or medical assistance;

~~(12)~~ (10) an independent living plan for a child 14 years of age or older, developed in consultation with the child. The child may select one member of the case planning team to be designated as the child's advisor and to advocate with respect to the application of the reasonable and prudent parenting standards in subdivision 14. The plan should include, but not be limited to, the following objectives:

(i) educational, vocational, or employment planning;

(ii) health care planning and medical coverage;

(iii) transportation including, where appropriate, assisting the child in obtaining a driver's license;

(iv) money management, including the responsibility of the responsible social services agency to ensure that the child annually receives, at no cost to the child, a consumer report as defined under section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report;

(v) planning for housing;

(vi) social and recreational skills;

(vii) establishing and maintaining connections with the child's family and community; and

(viii) regular opportunities to engage in age-appropriate or developmentally appropriate activities typical for the child's age group, taking into consideration the capacities of the individual child;

~~(13)~~ (11) for a child in voluntary foster care for treatment under chapter 260D, diagnostic and assessment information, specific services relating to meeting the mental health care needs of the child, and treatment outcomes;

~~(14)~~ (12) for a child 14 years of age or older, a signed acknowledgment that describes the child's rights regarding education, health care, visitation, safety and protection from exploitation, and court participation; receipt of the documents identified in section 260C.452; and receipt of an annual credit report. The acknowledgment shall state that the rights were explained in an age-appropriate manner to the child; and

~~(15)~~ (13) for a child placed in a qualified residential treatment program, the plan must include the requirements in section 260C.708.

~~(d)~~ (e) The parent or parents or guardian and the child each shall have the right to legal counsel in the preparation of the case plan and shall be informed of the right at the time of placement of the child. The child shall also have the right to a guardian ad litem. If unable to employ counsel from their own resources, the court shall appoint counsel upon the request of the parent or parents or the child or the child's legal guardian. The parent or parents may also receive assistance from any person or social services agency in preparation of the case plan.

~~(e) Before an out of home placement plan is signed by the parent or parents or guardian of the child, the responsible social services agency must provide the parent or parents or guardian with a one- to two-page summary of the plan using a form developed by the commissioner. The out of home placement plan summary must clearly summarize the plan's contents under paragraph (c) and list the requirements and responsibilities for the parent or parents or guardian using plain language. The summary must be updated and provided to the parent or parents or guardian when the out of home placement plan is updated under subdivision 1a.~~

(f) After the plan has been agreed upon by the parties involved or approved or ordered by the court, the foster parents shall be fully informed of the provisions of the case plan and shall be provided a copy of the plan.

(g) Upon the child's discharge from foster care, the responsible social services agency must provide the child's parent, adoptive parent, or permanent legal and physical custodian, and the child, if the child is 14 years of age or older, with a current copy of the child's health and education record. If a child meets the conditions in subdivision 15, paragraph (b), the agency must also provide the child with the child's social and medical history. The responsible social services agency may give a copy of the child's health and education record and social and medical history to a child who is younger than 14 years of age, if it is appropriate and if subdivision 15, paragraph (b), applies.

Sec. 25. Minnesota Statutes 2024, section 260C.212, subdivision 1a, is amended to read:

Subd. 1a. **Out-of-home placement plan update.** (a) Within 30 days of placing the child in foster care, the agency must complete the child's out-of-home placement plan summary and file it with the court. Within 60 days of placing the child in foster care, the agency must file the child's initial out-of-home placement plan with the court. After filing the child's ~~initial~~ out-of-home placement plan, the agency shall update and file the child's out-of-home placement plan with the court as follows:

(1) when the agency moves a child to a different foster care setting, the agency shall inform the court within 30 days of the child's placement change or court-ordered trial home visit. The agency must file the child's updated out-of-home placement plan summary and out-of-home placement plan with the court at the next required review hearing;

(2) when the agency places a child in a qualified residential treatment program as defined in section 260C.007, subdivision 26d, or moves a child from one qualified residential treatment program to a different qualified residential treatment program, the agency must update the child's out-of-home placement plan within 60 days. To meet the requirements of section 260C.708, the agency must file the child's out-of-home placement plan along with the agency's report seeking the court's approval of the child's placement at a qualified residential treatment program under section 260C.71. After the court issues an order, the agency must update the child's out-of-home placement plan to document the court's approval or disapproval of the child's placement in a qualified residential treatment program;

(3) when the agency places a child with the child's parent in a licensed residential family-based substance use disorder treatment program under section 260C.190, the agency must identify the treatment program where the child will be placed in the child's out-of-home placement plan prior to the child's placement. The agency must file the child's out-of-home placement plan summary and out-of-home placement plan with the court at the next required review hearing; and

(4) under sections 260C.227 and 260C.521, the agency must update the child's out-of-home placement plan summary and out-of-home placement plan and file the child's out-of-home placement plan with the court.

(b) When none of the items in paragraph (a) apply, the agency must update the child's out-of-home placement plan summary and out-of-home placement plan no later than 180 days after the child's initial placement and every six months thereafter, consistent with section 260C.203, paragraph (a).

Sec. 26. Minnesota Statutes 2024, section 260C.221, subdivision 2, is amended to read:

Subd. 2. **Relative notice requirements.** (a) The agency may provide oral or written notice to a child's relatives. In the child's case record, the agency must document providing the required notice to each of the child's relatives. The responsible social services agency must notify relatives:

(1) of the need for a foster home for the child, the option to become a placement resource for the child, the order of placement that the agency will consider under section 260C.212, subdivision 2, paragraph (a), and the possibility of the need for a permanent placement for the child;

(2) of their responsibility to keep the responsible social services agency and the court informed of their current address in order to receive notice in the event that a permanent placement is sought for the child and to receive notice of the permanency progress review hearing under section 260C.204. A relative who fails to provide a current address to the responsible social services agency and the court forfeits the right to receive notice of the possibility of permanent placement and of the permanency progress review hearing under section 260C.204, until the relative provides a current address to the responsible social services agency and the court. A decision by a relative not to be

identified as a potential permanent placement resource or participate in planning for the child shall not affect whether the relative is considered for placement of, or as a permanency resource for, the child with that relative at any time in the case, and shall not be the sole basis for the court to rule out the relative as the child's placement or permanency resource;

(3) that the relative may participate in the care and planning for the child, as specified in subdivision 3, including that the opportunity for such participation may be lost by failing to respond to the notice sent under this subdivision;

(4) of the family foster care licensing and adoption home study requirements and supports, including ~~how to complete an application and how to request a variance from licensing standards that do not present a safety or health risk to the child in the home under section 142B.10 and supports that are available for relatives and children who reside in a family foster home;~~:

(i) the choice between county or private agency licensing and services under section 142B.05, subdivision 3;

(ii) how to complete an application;

(iii) how to request a variance from licensing standards that do not present a safety or health risk to the child in the home under section 142B.10; and

(iv) supports that are available for relatives and children who reside in a family foster home, including but not limited to ways to include resource or substitute caregivers in the child's case plan, strategies for leveraging the child and family's natural supports, and how to access legal services and support and respite care;

(5) of the relatives' right to ask to be notified of any court proceedings regarding the child, to attend the hearings, and of a relative's right to be heard by the court as required under section 260C.152, subdivision 5;

(6) that regardless of the relative's response to the notice sent under this subdivision, the agency is required to establish permanency for a child, including planning for alternative permanency options if the agency's reunification efforts fail or are not required; and

(7) that by responding to the notice, a relative may receive information about participating in a child's family and permanency team if the child is placed in a qualified residential treatment program as defined in section 260C.007, subdivision 26d.

(b) The responsible social services agency shall send the notice required under paragraph (a) to relatives who become known to the responsible social services agency, except for relatives that the agency does not contact due to safety reasons under subdivision 5, paragraph (b). The responsible social services agency shall continue to send notice to relatives notwithstanding a court's finding that the agency has made reasonable efforts to conduct a relative search.

(c) The responsible social services agency is not required to send the notice under paragraph (a) to a relative who becomes known to the agency after an adoption placement agreement has been fully executed under section 260C.613, subdivision 1. If the relative wishes to be considered for adoptive placement of the child, the agency shall inform the relative of the relative's ability to file a motion for an order for adoptive placement under section 260C.607, subdivision 6.

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

Sec. 27. Minnesota Statutes 2024, section 260C.223, subdivision 1, is amended to read:

Subdivision 1. **Program; goals.** (a) The commissioner of children, youth, and families shall establish a program for concurrent permanency planning for child protection services.

(b) Concurrent permanency planning involves a planning process for children who are placed out of the home of their parents pursuant to a court order, or who have been voluntarily placed out of the home by the parents for 60 days or more and who are not developmentally disabled or emotionally disabled under section 260C.212, subdivision 9. The responsible social services agency shall develop an alternative permanency plan while making reasonable efforts for reunification of the child with the family, if required by section 260.012. The goals of concurrent permanency planning are to:

(1) achieve early permanency for children;

(2) decrease children's length of stay in foster care and reduce the number of moves children experience in foster care; and

(3) ~~develop a group of families~~ establish a foster parent for a child who will work ~~towards~~ toward reunification and also serve as a permanent ~~families~~ family for children.

Sec. 28. Minnesota Statutes 2024, section 260C.223, subdivision 2, is amended to read:

Subd. 2. **Development of guidelines and protocols.** (a) The commissioner shall establish guidelines and protocols for social services agencies involved in concurrent permanency planning, including criteria for conducting concurrent permanency planning based on relevant factors such as:

(1) age of the child and duration of out-of-home placement;

(2) prognosis for successful reunification with parents;

(3) availability of relatives and other concerned individuals to provide support or a permanent placement for the child; and

(4) special needs of the child and other factors affecting the child's best interests.

(b) In developing the guidelines and protocols, the commissioner shall consult with interest groups within the child protection system, including child protection workers, child protection advocates, county attorneys, law enforcement, community service organizations, the councils of color, and the ombudsperson for families.

(c) The responsible social services agency must not make a foster family the permanent home for a child until:

(1) inquiry and Tribal notice requirements under section 260.761, subdivisions 1 and 2, are satisfied;

(2) inquiry about the child's heritage, including their race, culture, and ethnicity pursuant to section 260.63, subdivision 10, has been completed; and

(3) the court has determined that reasonable or active efforts toward completing the relative search requirements in section 260C.221 have been made.

Sec. 29. Minnesota Statutes 2024, section 260C.329, subdivision 3, is amended to read:

Subd. 3. **Petition.** (a) The following individuals may file a petition for the reestablishment of the legal parent and child relationship:

(1) county attorney~~,~~;

(2) a parent whose parental rights were terminated under a previous order of the court~~,~~;

(3) a parent whose voluntary consent to adoption was accepted by the court and:

(i) the identified prospective adoptive parent did not finalize the adoption; or

(ii) the adoption finalized but subsequently dissolved and the child returned to foster care and guardianship of the commissioner;

(4) a child who is ten years of age or older~~,~~;

(5) the responsible social services agency~~,~~; or

(6) a guardian ad litem ~~may file a petition for the reestablishment of the legal parent and child relationship~~.

(b) A parent filing a petition under this section shall pay a filing fee in the amount required under section 357.021, subdivision 2, clause (1). The filing fee may be waived pursuant to chapter 563. A petition for the reestablishment of the legal parent and child relationship may be filed when:

(1) the parent has corrected the conditions that led to an order terminating parental rights;

(2) the parent is willing and has the capability to provide day-to-day care and maintain the health, safety, and welfare of the child;

(3) the child has been in foster care for at least 24 months after the court issued the order terminating parental rights;

(4) the child ~~has~~ is not ~~been~~ currently adopted; and

(5) the child is not the subject of a written adoption placement agreement between the responsible social services agency and the prospective adoptive parent, as required under Minnesota Rules, part 9560.0060, subpart 2.

Sec. 30. Minnesota Statutes 2024, section 260C.329, subdivision 8, is amended to read:

Subd. 8. **Hearing.** The court may grant the petition ordering the reestablishment of the legal parent and child relationship only if it finds by clear and convincing evidence that:

(1) reestablishment of the legal parent and child relationship is in the child's best interests;

(2) the child ~~has~~ is not ~~been~~ currently adopted;

(3) the child is not the subject of a written adoption placement agreement between the responsible social services agency and the prospective adoptive parent, as required under Minnesota Rules, part 9560.0060, subpart 2;

(4) at least 24 months have elapsed following a final order terminating parental rights and the child remains in foster care;

(5) the child desires to reside with the parent;

(6) the parent has corrected the conditions that led to an order terminating parental rights; and

(7) the parent is willing and has the capability to provide day-to-day care and maintain the health, safety, and welfare of the child.

Sec. 31. Minnesota Statutes 2024, section 260C.451, subdivision 9, is amended to read:

Subd. 9. **Administrative or court review of placements.** (a) The court ~~shall~~ must conduct reviews at least annually to ensure the responsible social services agency is making reasonable efforts to finalize the permanency plan for the child.

(b) The responsible social services agency must file a written report with the court containing or attaching the following:

(1) the child's name, date of birth, race, gender, and current address;

(2) a written summary describing planning with the child, including supports and services to ensure the child's safety, housing stability, well-being needs, and independent living skills;

(3) the child's most recent out-of-home placement plan and independent living plan required under section 260C.212, subdivision 1;

(4) if the child's plan is to not continue in extended foster care or if the child will reach age 21 before the next review, a copy of their 180-day transition plan as required in section 260C.452, subdivision 4; and

(5) if the agency plans to transition the child into adult services, a summary of the transition plan as required in section 260C.452, subdivision 4, and how this plan is in the child's best interest.

~~(b)~~ (c) The court ~~shall~~ must find that the responsible social services agency is making reasonable efforts to finalize the permanency plan for the child when the responsible social services agency:

(1) provides appropriate support to the child and caregiver or foster ~~care provider~~ parent to ensure continuing stability and success in placement;

(2) works with the child to plan for transition to adulthood and assists the child in demonstrating progress in achieving related goals;

(3) works with the child to plan for independent living skills and assists the child in demonstrating progress in achieving independent living goals; and

(4) prepares the child for independence according to sections 260C.203, paragraph (d), and 260C.452, subdivision 4.

~~(c)~~ (d) The responsible social services agency must ensure that an administrative review that meets the requirements of this section and section 260C.203 is completed at least six months after each of the court's annual reviews.

Sec. 32. Minnesota Statutes 2024, section 260C.452, subdivision 4, is amended to read:

Subd. 4. **Administrative or court review of placements.** (a) When the youth is 14 years of age or older, the court, in consultation with the youth, shall review the youth's independent living plan according to section 260C.203, paragraph (d).

(b) The responsible social services agency shall file a copy of the notification of foster care benefits for a youth who is 18 years of age or older according to section 260C.451, subdivision 1, with the court. If the responsible social services agency does not file the notice by the time the youth is 17-1/2 years of age, the court shall require the responsible social services agency to file the notice.

(c) When a youth is 18 years of age or older, the court shall ensure that the responsible social services agency assists the youth in obtaining the following documents before the youth leaves foster care: a Social Security card; an official or certified copy of the youth's birth certificate; a state identification card or driver's license, Tribal enrollment identification card, ~~green~~ permanent resident card, or school visa; health insurance information; the youth's school, medical, and dental records; a contact list of the youth's medical, dental, and mental health providers; and contact information for the youth's siblings, if the siblings are in foster care.

(d) For a youth who will be discharged from foster care at 18 years of age or older because the youth is not eligible for extended foster care benefits or chooses to leave foster care, the responsible social services agency must develop a personalized transition plan as directed by the youth during the 180-day period immediately prior to the expected date of discharge. The transition plan must be as detailed as the youth elects and include specific options, including but not limited to:

(1) affordable housing with necessary supports that does not include a homeless shelter;

(2) health insurance, including eligibility for medical assistance as defined in section 256B.055, subdivision 17;

(3) education, including application to the Education and Training Voucher Program;

(4) local opportunities for mentors and continuing support services;

(5) workforce supports and employment services;

(6) a copy of the youth's consumer credit report as defined in section 13C.001 and assistance in interpreting and resolving any inaccuracies in the report, at no cost to the youth;

(7) information on executing a health care directive under chapter 145C and on the importance of designating another individual to make health care decisions on behalf of the youth if the youth becomes unable to participate in decisions;

(8) appropriate contact information through 21 years of age if the youth needs information or help dealing with a crisis situation; and

(9) official documentation that the youth was previously in foster care.

Sec. 33. Minnesota Statutes 2024, section 260E.03, subdivision 15, is amended to read:

Subd. 15. **Neglect.** (a) "Neglect" means the commission or omission of any of the acts specified under clauses (1) to (8), other than by accidental means:

(1) failure by a person responsible for a child's care to supply a child with necessary food, clothing, shelter, health, medical, or other care required for the child's physical or mental health when reasonably able to do so;

(2) failure to protect a child from conditions or actions that seriously endanger the child's physical or mental health when reasonably able to do so, including a growth delay, which may be referred to as a failure to thrive, that has been diagnosed by a physician and is due to parental neglect;

(3) failure to provide for necessary supervision or child care arrangements appropriate for a child after considering factors as the child's age, mental ability, physical condition, length of absence, or environment, when the child is unable to care for the child's own basic needs or safety, or the basic needs or safety of another child in their care;

(4) failure to ensure that the child is educated as defined in sections 120A.22 and 260C.163, subdivision 11, which does not include a parent's refusal to provide the parent's child with sympathomimetic medications, consistent with section 125A.091, subdivision 5;

(5) prenatal exposure to a controlled substance, as defined in section 253B.02, subdivision 2, used by the mother for a nonmedical purpose, as evidenced by withdrawal symptoms in the child at birth, results of a toxicology test performed on the mother at delivery or the child at birth, medical effects or developmental delays during the child's first year of life that medically indicate prenatal exposure to a controlled substance, or the presence of a fetal alcohol spectrum disorder;

(6) medical neglect, as defined in section 260C.007, subdivision 6, clause (5);

(7) chronic and severe use of alcohol or a controlled substance by a person responsible for the child's care that adversely affects the child's basic needs and safety; or

(8) emotional harm from a pattern of behavior that contributes to impaired emotional functioning of the child which may be demonstrated by a substantial and observable effect in the child's behavior, emotional response, or cognition that is not within the normal range for the child's age and stage of development, with due regard to the child's culture.

(b) Nothing in this chapter shall be construed to mean that a child is neglected solely because the child's parent, guardian, or other person responsible for the child's care in good faith selects and depends upon spiritual means or prayer for treatment or care of disease or remedial care of the child in lieu of medical care.

(c) This chapter does not impose upon persons not otherwise legally responsible for providing a child with necessary food, clothing, shelter, education, or medical care a duty to provide that care.

(d) Nothing in this chapter shall be construed to mean that a child who has a mental, physical, or emotional condition is neglected solely because the child remains in an emergency department or hospital setting because services, including residential treatment, that are deemed necessary by the child's medical or mental health care professional or county case manager are not available to the child's parent, guardian, or other person responsible for the child's care, and the child cannot be safely discharged to the child's family.

Sec. 34. Minnesota Statutes 2024, section 260E.09, is amended to read:

260E.09 REPORTING REQUIREMENTS.

(a) An oral report shall be made immediately by telephone or otherwise. An oral report made by a person required under section 260E.06, subdivision 1, to report shall be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the appropriate police department, the county sheriff, the agency responsible for assessing or investigating the report, or the local welfare agency.

(b) Any report shall be of sufficient content to identify the child, any person believed to be responsible for the maltreatment of the child if the person is known, the nature and extent of the maltreatment, and the name and address of the reporter. The local welfare agency or agency responsible for assessing or investigating the report shall accept a report made under section 260E.06 notwithstanding refusal by a reporter to provide the reporter's name or address as long as the report is otherwise sufficient under this paragraph. The local welfare agency or agency responsible for assessing or investigating the report shall ask the reporter if the reporter is aware of the child or family heritage, including the child's Tribal lineage pursuant to section 260.761 and their race, culture, and ethnicity pursuant to section 260.63, subdivision 10.

(c) Notwithstanding paragraph (a), upon implementation of the provider licensing and reporting hub, an individual who has an account with the provider licensing and reporting hub and is required to report suspected maltreatment at a licensed program under section 260E.06, subdivision 1, may submit a written report in the hub in a manner prescribed by the commissioner and is not required to make an oral report. A report submitted through the provider licensing and reporting hub must be made immediately.

Sec. 35. Minnesota Statutes 2024, section 260E.20, subdivision 1, is amended to read:

Subdivision 1. **General duties.** (a) The local welfare agency shall offer services to prevent future maltreatment, safeguarding and enhancing the welfare of the maltreated child, and supporting and preserving family life whenever possible.

(b) If the report alleges a violation of a criminal statute involving maltreatment or child endangerment under section 609.378, the local law enforcement agency and local welfare agency shall coordinate the planning and execution of their respective investigation and assessment efforts to avoid a duplication of fact-finding efforts and multiple interviews. Each agency shall prepare a separate report of the results of the agency's investigation or assessment.

(c) In cases of alleged child maltreatment resulting in death, the local agency may rely on the fact-finding efforts of a law enforcement investigation to make a determination of whether or not maltreatment occurred.

(d) When necessary, the local welfare agency shall seek authority to remove the child from the custody of a parent, guardian, or adult with whom the child is living.

(e) In performing any of these duties, the local welfare agency shall maintain an appropriate record.

(f) In conducting a family assessment, noncaregiver human trafficking assessment, or investigation, the local welfare agency shall gather information on the existence of substance abuse and domestic violence.

(g) If the family assessment, noncaregiver human trafficking assessment, or investigation indicates there is a potential for abuse of alcohol or other drugs by the parent, guardian, or person responsible for the child's care, the local welfare agency must coordinate a comprehensive assessment pursuant to section 245G.05.

(h) The agency may use either a family assessment or investigation to determine whether the child is safe when responding to a report resulting from birth match data under section 260E.03, subdivision 23, paragraph (c). If the child subject of birth match data is determined to be safe, the agency shall consult with the county attorney to determine the appropriateness of filing a petition alleging the child is in need of protection or services under section 260C.007, subdivision 6, clause (16), in order to deliver needed services. If the child is determined not to be safe, the agency and the county attorney shall take appropriate action as required under section 260C.503, subdivision 2.

(i) When conducting any assessment or investigation, the agency shall ask the child, if age appropriate; parents; extended family; and reporter about the child's family heritage, including the child's Tribal lineage pursuant to section 260.761 and the child's race, culture, and ethnicity pursuant to section 260.63, subdivision 10.

Sec. 36. Minnesota Statutes 2024, section 260E.20, subdivision 3, is amended to read:

Subd. 3. **Collection of information.** (a) The local welfare agency responsible for conducting a family assessment, noncaregiver human trafficking assessment, or investigation shall collect available and relevant information to determine child safety, risk of subsequent maltreatment, and family strengths and needs and share not public information with an Indian's Tribal social services agency without violating any law of the state that may otherwise impose a duty of confidentiality on the local welfare agency in order to implement the Tribal state agreement.

(b) The local welfare agency or the agency responsible for investigating the report shall collect available and relevant information to ascertain whether maltreatment occurred and whether protective services are needed.

(c) Information collected includes, when relevant, information regarding the person reporting the alleged maltreatment, including the nature of the reporter's relationship to the child and to the alleged offender, and the basis of the reporter's knowledge for the report; the child allegedly being maltreated; the alleged offender; the child's caretaker; and other collateral sources having relevant information related to the alleged maltreatment.

(d) Information relevant to the assessment or investigation must be requested, and may include:

(1) the child's sex and age; prior reports of maltreatment, including any maltreatment reports that were screened out and not accepted for assessment or investigation; information relating to developmental functioning; credibility of the child's statement; and whether the information provided under this clause is consistent with other information collected during the course of the assessment or investigation;

(2) except in a noncaregiver human trafficking assessment, the alleged offender's age, a record check for prior reports of maltreatment, and criminal charges and convictions;

(3) collateral source information regarding the alleged maltreatment and care of the child. Collateral information includes, when relevant: (i) a medical examination of the child; (ii) prior medical records relating to the alleged maltreatment or the care of the child maintained by any facility, clinic, or health care professional and an interview with the treating professionals; and (iii) interviews with the child's caretakers, including the child's parent, guardian, foster parent, child care provider, teachers, counselors, family members, relatives, and other persons who may have knowledge regarding the alleged maltreatment and the care of the child; and

(4) information on the existence of domestic abuse and violence in the home of the child, and substance abuse.

(e) Nothing in this subdivision precludes the local welfare agency, the local law enforcement agency, or the agency responsible for assessing or investigating the report from collecting other relevant information necessary to conduct the assessment or investigation.

(f) Notwithstanding section 13.384 or 144.291 to 144.298, the local welfare agency has access to medical data and records for purposes of paragraph (d), clause (3).

Sec. 37. **[260E.215] REPORTING OF SCHOOL ATTENDANCE CONCERNS.**

Subdivision 1. **Reports required.** (a) A person mandated to report under this chapter must immediately report to the local welfare agency or designated partner if the person knows or has reason to believe that a child required to be enrolled in school under section 120A.22 has at least seven unexcused absences in the current school year and is at risk of educational neglect or truancy under section 260C.163, subdivision 11.

(b) Any person may make a voluntary report if the person knows or has reason to believe that a child required to be enrolled in school under section 120A.22 has at least seven unexcused absences in the current school year and is at risk of educational neglect or truancy under section 260C.163, subdivision 11.

(c) An oral report must be made immediately. An oral report made by a person required to report under paragraph (a) must be followed within 72 hours, exclusive of weekends and holidays, by a report in writing to the local welfare agency. A report must sufficiently identify the child and the child's parent or guardian, the actual or estimated number of the child's unexcused absences in the current school year, the efforts made by school officials to resolve attendance concerns with the family, and the name and address of the reporter. A voluntary reporter under paragraph (b) may refuse to provide their name or address if the report is otherwise sufficient, and the local welfare agency must accept such a report.

Subd. 2. **Local welfare agency.** (a) The local welfare agency or partner designated to provide child welfare services must provide a child welfare response for a report that alleges a child enrolled in school has seven or more unexcused absences. When providing a child welfare response under this paragraph, the local welfare agency or designated partner must offer services to the child and the child's family to address school attendance concerns or may partner with a county attorney's office, a community-based organization, or other community partner to provide the services. The services must be culturally and linguistically appropriate and tailored to the needs of the child and the child's family. This section is subject to the requirements of the Minnesota Indian Family Preservation Act under sections 260.751 to 260.835 and the Minnesota African American Family Preservation and Child Welfare Disproportionality Act under sections 260.61 to 260.693.

(b) If the unexcused absences continue and the family has not engaged with services under paragraph (a) after the local welfare agency or partner designated to provide child welfare services has made multiple varied attempts to engage the child's family, a report of educational neglect must be made regardless of the number of unexcused absences the child has accrued. The local welfare agency must determine the response path assignment pursuant to section 260E.17 and may proceed with the process outlined in section 260C.141.

Sec. 38. Minnesota Statutes 2024, section 260E.24, subdivision 1, is amended to read:

Subdivision 1. **Timing.** The local welfare agency shall conclude the family assessment, the noncaregiver human trafficking assessment, or the investigation within 45 days of the receipt of a report. The conclusion of the assessment or investigation may be extended to permit the completion of a criminal investigation or the receipt of expert information requested within 45 days of the receipt of the report.

Sec. 39. Minnesota Statutes 2024, section 260E.24, subdivision 2, is amended to read:

Subd. 2. **Determination after family assessment or a noncaregiver human trafficking assessment.** After conducting a family assessment or a noncaregiver human trafficking assessment, the local welfare agency shall determine whether child protective services are needed to address the safety of the child and other family members and the risk of subsequent maltreatment. The local welfare agency must document the information collected under section 260E.20, subdivision 3, related to the completed family assessment or noncaregiver human trafficking assessment in the child's or family's case notes.

Sec. 40. **REVISOR INSTRUCTION.**

The revisor of statutes shall change paragraphs to subdivisions, clauses to paragraphs, and items to clauses in Minnesota Statutes, sections 260C.203 and 260C.204. The revisor shall make any necessary grammatical changes or changes to sentence structure necessary to preserve the meaning of the text as a result of the changes. The revisor of statutes must correct any statutory cross-references consistent with the changes in this section.

ARTICLE 9
CHILD PROTECTION AND WELFARE FINANCE

Section 1. Minnesota Statutes 2024, section 142A.03, subdivision 2, is amended to read:

Subd. 2. **Duties of the commissioner.** (a) The commissioner may apply for and accept on behalf of the state any grants, bequests, gifts, or contributions for the purpose of carrying out the duties and responsibilities of the commissioner. Any money received under this paragraph is appropriated and dedicated for the purpose for which the money is granted. The commissioner must biennially report to the chairs and ranking minority members of relevant legislative committees and divisions by January 15 of each even-numbered year a list of all grants and gifts received under this subdivision.

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

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

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

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

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

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

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

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

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

(e) The commissioner shall administer and supervise the forms of public assistance and other activities or services that are vested in the commissioner. Administration and supervision of activities or services includes but is not limited to assuring timely and accurate distribution of benefits, completeness of service, and quality program management. In addition to administering and supervising activities vested by law in the department, the commissioner has the authority to:

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

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

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

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

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

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

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

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

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

(g) The commissioner shall administer and supervise child welfare activities, including promoting the enforcement of laws preventing child maltreatment and protecting children with a disability and children who are in need of protection or services, licensing and supervising child care and child-placing agencies, and supervising the care of children in foster care. The commissioner shall coordinate with the commissioner of human services on activities impacting children overseen by the Department of Human Services, such as disability services, behavioral health, and substance use disorder treatment.

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

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

(j) The commissioner shall act as designated guardian of children pursuant to chapter 260C. For children under the guardianship of the commissioner or a Tribe in Minnesota recognized by the Secretary of the Interior whose interests would be best served by adoptive placement, the commissioner may contract with a licensed child-placing agency or a Minnesota Tribal social services agency to provide adoption services. <u>For children in out-of-home care whose interests would be best served by a transfer of permanent legal and physical custody to a relative under section 260C.515, subdivision 4, or equivalent in Tribal code, the commissioner may contract with a licensed child-placing agency or a Minnesota Tribal social services agency to provide permanency services.</u> A contract with a licensed child-placing agency must be designed to supplement existing county efforts and may not replace existing

county programs or Tribal social services, unless the replacement is agreed to by the county board and the appropriate exclusive bargaining representative, Tribal governing body, or the commissioner has evidence that child placements of the county continue to be substantially below that of other counties. Funds encumbered and obligated under an agreement for a specific child shall remain available until the terms of the agreement are fulfilled or the agreement is terminated.

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

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

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

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

(m) The commissioner shall allocate federal fiscal disallowances or sanctions that are based on quality control error rates for the aid to families with dependent children (AFDC) program formerly codified in sections 256.72 to 256.87 or the Supplemental Nutrition Assistance Program (SNAP) in the following manner:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(t) The commissioner shall authorize the method of payment to or from the department as part of the programs administered by the department. This authorization includes the receipt or disbursement of funds held by the department in a fiduciary capacity as part of the programs administered by the department.

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

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

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

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

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

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

(aa) The commissioner shall have the power and authority to accept on behalf of the state contributions and gifts for the use and benefit of children under the guardianship or custody of the commissioner. The commissioner may also receive and accept on behalf of such children money due and payable to them as old age and survivors insurance benefits, veterans benefits, pensions, or other such monetary benefits. Gifts, contributions, pensions, and benefits under this paragraph must be deposited in and disbursed from the social welfare fund provided for in sections 256.88 to 256.92.

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

Sec. 2. Minnesota Statutes 2024, section 260.810, subdivision 1, is amended to read:

Subdivision 1. **Payments.** The commissioner shall make grant payments to each approved program in four quarterly installments a year. The commissioner may certify an advance payment for the first quarter of the state fiscal year. Later payments must be made ~~upon receipt by the state of a quarterly report on finances and program activities~~ quarterly.

Sec. 3. Minnesota Statutes 2024, section 260.810, subdivision 2, is amended to read:

Subd. 2. ~~**Quarterly report**~~ **Reporting.** The commissioner shall ~~specify~~ engage Tribal and urban Indian organizations to establish requirements for reports and reporting timelines, including ~~quarterly~~ fiscal reports submitted to the commissioner at least annually, according to section 142A.03, subdivision 2, paragraph (o). Each ~~quarter~~ reporting period as agreed upon by the commissioner and grantee, an approved program receiving an Indian child welfare grant shall submit a report to the commissioner that includes:

(1) a detailed accounting of grant money expended during the preceding ~~quarter~~ reporting period, specifying expenditures by line item and year to date; and

(2) a description of Indian child welfare activities conducted during the preceding ~~quarter~~ reporting period, including the number of clients served and the type of services provided.

~~The quarterly~~ Reports must be submitted no later than 30 days after the ~~end of each quarter~~ agreed upon reporting timelines of the state fiscal year.

Sec. 4. Minnesota Statutes 2024, section 260.821, subdivision 2, is amended to read:

Subd. 2. **Special focus grants.** The amount available for grants established under section 260.785, subdivision 2, for child-placing agencies, Tribes, Indian organizations, and other social services organizations is one-fifth of the total annual appropriation for Indian child welfare grants. ~~The maximum award under this subdivision is $100,000 a year for programs approved by the commissioner.~~

Sec. 5. Minnesota Statutes 2024, section 518.68, subdivision 2, is amended to read:

Subd. 2. **Contents.** (a) This subdivision expires January 1, 2027. For orders issued prior to January 1, 2027, the required notices must be substantially as follows:

IMPORTANT NOTICE

1. PAYMENTS TO PUBLIC AGENCY

According to Minnesota Statutes, section 518A.50, payments ordered for maintenance and support must be paid to the public agency responsible for child support enforcement as long as the person entitled to receive the payments is receiving or has applied for public assistance or has applied for support and maintenance collection services. MAIL PAYMENTS TO:

2. DEPRIVING ANOTHER OF CUSTODIAL OR PARENTAL RIGHTS -- A FELONY

A person may be charged with a felony who conceals a minor child or takes, obtains, retains, or fails to return a minor child from or to the child's parent (or person with custodial or visitation rights), according to Minnesota Statutes, section 609.26. A copy of that section is available from any district court clerk.

3. NONSUPPORT OF A SPOUSE OR CHILD -- CRIMINAL PENALTIES

A person who fails to pay court-ordered child support or maintenance may be charged with a crime, which may include misdemeanor, gross misdemeanor, or felony charges, according to Minnesota Statutes, section 609.375. A copy of that section is available from any district court clerk.

4. RULES OF SUPPORT, MAINTENANCE, PARENTING TIME

(a) Payment of support or spousal maintenance is to be as ordered, and the giving of gifts or making purchases of food, clothing, and the like will not fulfill the obligation.

(b) Payment of support must be made as it becomes due, and failure to secure or denial of parenting time is NOT an excuse for nonpayment, but the aggrieved party must seek relief through a proper motion filed with the court.

(c) Nonpayment of support is not grounds to deny parenting time. The party entitled to receive support may apply for support and collection services, file a contempt motion, or obtain a judgment as provided in Minnesota Statutes, section 548.091.

(d) The payment of support or spousal maintenance takes priority over payment of debts and other obligations.

(e) A party who accepts additional obligations of support does so with the full knowledge of the party's prior obligation under this proceeding.

(f) Child support or maintenance is based on annual income, and it is the responsibility of a person with seasonal employment to budget income so that payments are made throughout the year as ordered.

(g) Reasonable parenting time guidelines are contained in Appendix B, which is available from the court administrator.

(h) The nonpayment of support may be enforced through the denial of student grants; interception of state and federal tax refunds; suspension of driver's, recreational, and occupational licenses; referral to the department of revenue or private collection agencies; seizure of assets, including bank accounts and other assets held by financial institutions; reporting to credit bureaus; income withholding and contempt proceedings; and other enforcement methods allowed by law.

(i) The public authority may suspend or resume collection of the amount allocated for child care expenses if the conditions of Minnesota Statutes, section 518A.40, subdivision 4, are met.

(j) The public authority may remove or resume a medical support offset if the conditions of Minnesota Statutes, section 518A.41, subdivision 16, are met.

5. MODIFYING CHILD SUPPORT

If either the obligor or obligee is laid off from employment or receives a pay reduction, child support may be modified, increased, or decreased. Any modification will only take effect when it is ordered by the court, and will only relate back to the time that a motion is filed. Either the obligor or obligee may file a motion to modify child support, and may request the public agency for help. UNTIL A MOTION IS FILED, THE CHILD SUPPORT OBLIGATION WILL CONTINUE AT THE CURRENT LEVEL. THE COURT IS NOT PERMITTED TO REDUCE SUPPORT RETROACTIVELY.

6. PARENTAL RIGHTS FROM MINNESOTA STATUTES, SECTION 518.17, SUBDIVISION 3

Unless otherwise provided by the Court:

(a) Each party has the right of access to, and to receive copies of, school, medical, dental, religious training, and other important records and information about the minor children. Each party has the right of access to information regarding health or dental insurance available to the minor children. Presentation of a copy of this order to the custodian of a record or other information about the minor children constitutes sufficient authorization for the release of the record or information to the requesting party.

(b) Each party shall keep the other informed as to the name and address of the school of attendance of the minor children. Each party has the right to be informed by school officials about the children's welfare, educational progress and status, and to attend school and parent teacher conferences. The school is not required to hold a separate conference for each party.

(c) In case of an accident or serious illness of a minor child, each party shall notify the other party of the accident or illness, and the name of the health care provider and the place of treatment.

(d) Each party has the right of reasonable access and telephone contact with the minor children.

7. WAGE AND INCOME DEDUCTION OF SUPPORT AND MAINTENANCE

Child support and/or spousal maintenance may be withheld from income, with or without notice to the person obligated to pay, when the conditions of Minnesota Statutes, section 518A.53 have been met. A copy of those sections is available from any district court clerk.

8. CHANGE OF ADDRESS OR RESIDENCE

Unless otherwise ordered, each party shall notify the other party, the court, and the public authority responsible for collection, if applicable, of the following information within ten days of any change: the residential and mailing address, telephone number, driver's license number, Social Security number, and name, address, and telephone number of the employer.

9. COST OF LIVING INCREASE OF SUPPORT AND MAINTENANCE

Prior to January 1, 2027, basic support and/or spousal maintenance may be adjusted every two years based upon a change in the cost of living (using Department of Labor Consumer Price Index....., unless otherwise specified in this order) when the conditions of Minnesota Statutes, section 518A.75, are met. Cost of living increases are compounded. A copy of Minnesota Statutes, section 518A.75, and forms necessary to request or contest a cost of living increase are available from any district court clerk.

10. JUDGMENTS FOR UNPAID SUPPORT

If a person fails to make a child support payment, the payment owed becomes a judgment against the person responsible to make the payment by operation of law on or after the date the payment is due, and the person entitled to receive the payment or the public agency may obtain entry and docketing of the judgment WITHOUT NOTICE to the person responsible to make the payment under Minnesota Statutes, section 548.091.

11. JUDGMENTS FOR UNPAID MAINTENANCE

(a) A judgment for unpaid spousal maintenance may be entered when the conditions of Minnesota Statutes, section 548.091, are met. A copy of that section is available from any district court clerk.

(b) The public authority is not responsible for calculating interest on any judgment for unpaid spousal maintenance. When providing services in IV-D cases, as defined in Minnesota Statutes, section 518A.26, subdivision 10, the public authority will only collect interest on spousal maintenance if spousal maintenance is reduced to a sum certain judgment.

12. ATTORNEY FEES AND COLLECTION COSTS FOR ENFORCEMENT OF CHILD SUPPORT

A judgment for attorney fees and other collection costs incurred in enforcing a child support order will be entered against the person responsible to pay support when the conditions of Minnesota Statutes, section 518A.735, are met. A copy of Minnesota Statutes, sections 518.14 and 518A.735 and forms necessary to request or contest these attorney fees and collection costs are available from any district court clerk.

13. PARENTING TIME EXPEDITOR PROCESS

On request of either party or on its own motion, the court may appoint a parenting time expeditor to resolve parenting time disputes under Minnesota Statutes, section 518.1751. A copy of that section and a description of the expeditor process is available from any district court clerk.

14. PARENTING TIME REMEDIES AND PENALTIES

Remedies and penalties for the wrongful denial of parenting time are available under Minnesota Statutes, section 518.175, subdivision 6. These include compensatory parenting time; civil penalties; bond requirements; contempt; and reversal of custody. A copy of that subdivision and forms for requesting relief are available from any district court clerk.

(b) For orders issued on or after January 1, 2027, the required notices must be substantially as follows:

IMPORTANT NOTICE

1. PAYMENTS TO PUBLIC AGENCY

According to Minnesota Statutes, section 518A.50, payments ordered for maintenance and support must be paid to the public agency responsible for child support enforcement as long as the person entitled to receive the payments is receiving or has applied for public assistance or has applied for support and maintenance collection services. MAIL PAYMENTS TO:

2. DEPRIVING ANOTHER OF CUSTODIAL OR PARENTAL RIGHTS -- A FELONY

A person may be charged with a felony who conceals a minor child or takes, obtains, retains, or fails to return a minor child from or to the child's parent (or person with custodial or visitation rights), according to Minnesota Statutes, section 609.26. A copy of that section is available from any district court clerk.

3. NONSUPPORT OF A SPOUSE OR CHILD -- CRIMINAL PENALTIES

A person who fails to pay court-ordered child support or maintenance may be charged with a crime, which may include misdemeanor, gross misdemeanor, or felony charges, according to Minnesota Statutes, section 609.375. A copy of that section is available from any district court clerk.

4. RULES OF SUPPORT, MAINTENANCE, PARENTING TIME

(a) Payment of support or spousal maintenance is to be as ordered, and the giving of gifts or making purchases of food, clothing, and the like will not fulfill the obligation.

(b) Payment of support must be made as it becomes due, and failure to secure or denial of parenting time is NOT an excuse for nonpayment, but the aggrieved party must seek relief through a proper motion filed with the court.

(c) Nonpayment of support is not grounds to deny parenting time. The party entitled to receive support may apply for support and collection services, file a contempt motion, or obtain a judgment as provided in Minnesota Statutes, section 548.091.

(d) The payment of support or spousal maintenance takes priority over payment of debts and other obligations.

(e) A party who accepts additional obligations of support does so with the full knowledge of the party's prior obligation under this proceeding.

(f) Child support or maintenance is based on annual income, and it is the responsibility of a person with seasonal employment to budget income so that payments are made throughout the year as ordered.

(g) Reasonable parenting time guidelines are contained in Appendix B, which is available from the court administrator.

(h) The nonpayment of support may be enforced through the denial of student grants; interception of state and federal tax refunds; suspension of driver's, recreational, and occupational licenses; referral to the Department of Revenue or private collection agencies; seizure of assets, including bank accounts and other assets held by financial institutions; reporting to credit bureaus; income withholding and contempt proceedings; and other enforcement methods allowed by law.

(i) The public authority may suspend or resume collection of the amount allocated for child care expenses if the conditions of Minnesota Statutes, section 518A.40, subdivision 4, are met.

(j) The public authority may remove or resume a medical support offset if the conditions of Minnesota Statutes, section 518A.41, subdivision 16, are met.

5. MODIFYING CHILD SUPPORT

If either the obligor or obligee is laid off from employment or receives a pay reduction, child support may be modified, increased, or decreased. Any modification will only take effect when it is ordered by the court, and will only relate back to the time that a motion is filed. Either the obligor or obligee may file a motion to modify child support, and may request the public agency for help. UNTIL A MOTION IS FILED, THE CHILD SUPPORT OBLIGATION WILL CONTINUE AT THE CURRENT LEVEL. THE COURT IS NOT PERMITTED TO REDUCE SUPPORT RETROACTIVELY.

6. PARENTAL RIGHTS FROM MINNESOTA STATUTES, SECTION 518.17, SUBDIVISION 3

Unless otherwise provided by the court:

(a) Each party has the right of access to, and to receive copies of, school, medical, dental, religious training, and other important records and information about the minor children. Each party has the right of access to information regarding health or dental insurance available to the minor children. Presentation of a copy of this order to the custodian of a record or other information about the minor children constitutes sufficient authorization for the release of the record or information to the requesting party.

(b) Each party shall keep the other informed as to the name and address of the school of attendance of the minor children. Each party has the right to be informed by school officials about the children's welfare, educational progress, and status, and to attend school and parent-teacher conferences. The school is not required to hold a separate conference for each party.

(c) In case of an accident or serious illness of a minor child, each party shall notify the other party of the accident or illness, and the name of the health care provider and the place of treatment.

(d) Each party has the right of reasonable access and telephone contact with the minor children.

7. WAGE AND INCOME DEDUCTION OF SUPPORT AND MAINTENANCE

Child support and/or spousal maintenance may be withheld from income, with or without notice to the person obligated to pay, when the conditions of Minnesota Statutes, section 518A.53, have been met. A copy of those sections is available from any district court clerk.

8. CHANGE OF ADDRESS OR RESIDENCE

Unless otherwise ordered, each party shall notify the other party, the court, and the public authority responsible for collection, if applicable, of the following information within ten days of any change: the residential and mailing address, telephone number, driver's license number, Social Security number, and name, address, and telephone number of the employer.

9. JUDGMENTS FOR UNPAID SUPPORT

If a person fails to make a child support payment, the payment owed becomes a judgment against the person responsible to make the payment by operation of law on or after the date the payment is due, and the person entitled to receive the payment or the public agency may obtain entry and docketing of the judgment WITHOUT NOTICE to the person responsible to make the payment under Minnesota Statutes, section 548.091.

10. JUDGMENTS FOR UNPAID MAINTENANCE

(a) A judgment for unpaid spousal maintenance may be entered when the conditions of Minnesota Statutes, section 548.091, are met. A copy of that section is available from any district court clerk.

(b) The public authority is not responsible for calculating interest on any judgment for unpaid spousal maintenance. When providing services in IV-D cases, as defined in Minnesota Statutes, section 518A.26, subdivision 10, the public authority will only collect interest on spousal maintenance if spousal maintenance is reduced to a sum certain judgment.

11. ATTORNEY FEES AND COLLECTION COSTS FOR ENFORCEMENT OF CHILD SUPPORT

A judgment for attorney fees and other collection costs incurred in enforcing a child support order will be entered against the person responsible to pay support when the conditions of Minnesota Statutes, section 518A.735, are met. A copy of Minnesota Statutes, sections 518.14 and 518A.735, and forms necessary to request or contest these attorney fees and collection costs are available from any district court clerk.

12. PARENTING TIME EXPEDITOR PROCESS

On request of either party or on its own motion, the court may appoint a parenting time expeditor to resolve parenting time disputes under Minnesota Statutes, section 518.1751. A copy of that section and a description of the expeditor process is available from any district court clerk.

13. PARENTING TIME REMEDIES AND PENALTIES

Remedies and penalties for the wrongful denial of parenting time are available under Minnesota Statutes, section 518.175, subdivision 6. These include compensatory parenting time, civil penalties, bond requirements, contempt, and reversal of custody. A copy of that subdivision and forms for requesting relief are available from any district court clerk.

Sec. 6. Minnesota Statutes 2024, section 518A.34, is amended to read:

518A.34 COMPUTATION OF CHILD SUPPORT OBLIGATIONS.

(a) To determine the presumptive child support obligation of a parent, the court shall follow the procedure set forth in this section.

(b) To determine the obligor's basic support obligation, the court shall:

(1) determine the gross income of each parent under section 518A.29;

(2) calculate the parental income for determining child support (PICS) of each parent, by subtracting from the gross income the credit, if any, for each parent's nonjoint children under section 518A.33;

(3) determine the percentage contribution of each parent to the combined PICS by dividing the combined PICS into each parent's PICS;

(4) determine the combined basic support obligation by application of the guidelines in section 518A.35;

(5) determine each parent's share of the combined basic support obligation by multiplying the percentage figure from clause (3) by the combined basic support obligation in clause (4); and

(6) apply the parenting expense adjustment formula provided in section 518A.36 to determine the obligor's basic support obligation.

(c) If the parents have split custody of joint children, child support must be calculated for each joint child as follows:

(1) the court shall determine each parent's basic support obligation under paragraph (b) and include the amount of each parent's obligation in the court order. If the basic support calculation results in each parent owing support to the other, the court shall offset the higher basic support obligation with the lower basic support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation. For the purpose of ~~the cost of living adjustment required under section 518A.75, the adjustment~~ a future modification, the application of section 518A.39 must be based on each parent's basic support obligation prior to offset. For the purposes of this paragraph, "split custody" means that there are two or more joint children and each parent has at least one joint child more than 50 percent of the time;

(2) if each parent pays all child care expenses for at least one joint child, the court shall calculate child care support for each joint child as provided in section 518A.40. The court shall determine each parent's child care support obligation and include the amount of each parent's obligation in the court order. If the child care support calculation results in each parent owing support to the other, the court shall offset the higher child care support obligation with the lower child care support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation; and

(3) if each parent pays all medical or dental insurance expenses for at least one joint child, medical support shall be calculated for each joint child as provided in section 518A.41. The court shall determine each parent's medical support obligation and include the amount of each parent's obligation in the court order. If the medical support calculation results in each parent owing support to the other, the court shall offset the higher medical support obligation with the lower medical support obligation to determine the amount to be paid by the parent with the higher obligation to the parent with the lower obligation. Unreimbursed and uninsured medical expenses are not included in the presumptive amount of support owed by a parent and are calculated and collected as provided in section 518A.41.

(d) The court shall determine the child care support obligation for the obligor as provided in section 518A.40.

(e) The court shall determine the medical support obligation for each parent as provided in section 518A.41. Unreimbursed and uninsured medical expenses are not included in the presumptive amount of support owed by a parent and are calculated and collected as described in section 518A.41.

(f) The court shall determine each parent's total child support obligation by adding together each parent's basic support, child care support, and health care coverage obligations as provided in this section.

(g) If Social Security benefits or veterans' benefits are received by one parent as a representative payee for a joint child based on the other parent's eligibility, the court shall subtract the amount of benefits from the other parent's net child support obligation, if any. Any benefit received by the obligee for the benefit of the joint child based upon the obligor's disability or past earnings in any given month in excess of the child support obligation must not be treated as an arrearage payment or a future payment.

(h) The final child support order shall separately designate the amount owed for basic support, child care support, and medical support. If applicable, the court shall use the self-support adjustment and minimum support adjustment under section 518A.42 to determine the obligor's child support obligation.

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

Sec. 7. Minnesota Statutes 2024, section 518A.46, subdivision 7, is amended to read:

Subd. 7. **Administrative redirection of support.** (a) The public authority must provide written notice of redirection to the obligee, the obligor, and the caregiver. The notice must be mailed to the obligor, obligee, and caregiver at the obligee's, the obligor's, and the caregiver's respective last known address. The notice must state the name of the child or children for whom support will be redirected, to whom the support will be redirected, the date the support will be redirected, and the amount of the support that will be redirected. The notice must also inform the parties of the right to contest the redirection of support according to paragraph (c).

(b) If fewer than all of the children for whom the support is ordered reside with the caregiver, the public authority must redirect the proportional share of the support for the number of children residing with the caregiver.

(c) The obligee or obligor may contest the redirection of support on the limited grounds that:

(1) the child or children do not reside or no longer reside with the caregiver;

(2) under an out-of-home placement plan under section 260C.212, subdivision 1, that includes a plan for reunification, all or part of the support is needed to maintain the obligee's home; or

(3) the redirection of support is not in the best interests of the child.

(d) To contest the redirection, the obligee or obligor must make a written request for a hearing to the public authority within 30 calendar days of the date of the written notice of redirection. The hearing must be held at the earliest practicable time, but no later than 30 calendar days from the date the public authority receives the written request for a hearing. If the public authority receives a timely written request for a hearing, the public authority must schedule a hearing and serve the obligee and the obligor with a notice of hearing at least 14 days before the date of the hearing. The notice must be served personally or by mail at the obligee's and the obligor's respective last known address. The public authority must file with the court the notice of hearing along with the notice of redirection at least five days before the scheduled hearing. The court administrator must schedule these hearings to be heard in the expedited process before a child support magistrate, but may schedule these hearings in district court if the availability of a child support magistrate does not permit a hearing to occur within the time frames of this subdivision.

(e) If neither the obligee nor the obligor contests the redirection of support under this subdivision, support must be redirected to the caregiver effective the first day of the month following the expiration of the time period to contest under paragraph (d). If the obligee or the obligor contests the redirection of support under paragraph (d), the public authority must not redirect support to the caregiver pending the outcome of the hearing.

(f) The redirection of the basic support, medical support, and child care support terminates and the public authority must direct support to the obligee if the public authority determines that:

(1) the caregiver for the child no longer receives public assistance for the child;

(2) the voluntary placement agreement expires; ~~or~~

(3) the court order placing the child is no longer in effect~~.~~; or

(4) the redirection of support is not in the best interests of the child as determined under section 260B.331, subdivision 1, or 260C.331, subdivision 1.

(g) The public authority must notify the obligee, obligor, and caregiver of a termination of the redirection of support by mailing a written notice to each of them at their last known address. The termination is effective the first day of the month that occurs at least 14 calendar days after the date the notice is mailed.

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

Sec. 8. Minnesota Statutes 2024, section 518A.75, subdivision 1, is amended to read:

Subdivision 1. **Requirement.** (a) An order establishing, modifying, or enforcing maintenance or child support shall provide for a biennial adjustment in the amount to be paid based on a change in the cost of living. An order that provides for a cost-of-living adjustment shall specify the cost-of-living index to be applied and the date on which the cost-of-living adjustment shall become effective. The court may use the Consumer Price Index for all urban consumers, Minneapolis-St. Paul (CPI-U), the Consumer Price Index for wage earners and clerical, Minneapolis-St. Paul (CPI-W), or another cost-of-living index published by the Department of Labor which it specifically finds is more appropriate. Cost-of-living increases under this section shall be compounded. The court may also increase the amount by more than the cost-of-living adjustment by agreement of the parties or by making further findings.

(b) The adjustment becomes effective on the first of May of the year in which it is made, for cases in which payment is made to the public authority. For cases in which payment is not made to the public authority, application for an adjustment may be made in any month but no application for an adjustment may be made sooner than two years after the date of the dissolution decree. A court may waive the requirement of the cost-of-living clause if it

expressly finds that the obligor's occupation or income, or both, does not provide for cost-of-living adjustment or that the order for maintenance or child support has a provision such as a step increase that has the effect of a cost-of-living clause. The court may waive a cost-of-living adjustment in a maintenance order if the parties so agree in writing. The commissioner of children, youth, and families may promulgate rules for child support adjustments under this section in accordance with the rulemaking provisions of chapter 14. Notice of this statute must comply with section 518.68, subdivision 2.

(c) No adjustment under this section shall be made after January 1, 2027, for any maintenance or child support order established before, on, or after January 1, 2027.

Sec. 9. **SOCIAL SERVICES INFORMATION SYSTEM MODERNIZATION.**

(a) The commissioner of children, youth, and families must improve and modernize the child welfare social services information system. Elements the commissioner must address as part of the system modernization include but are not limited to:

(1) capabilities that support case intake, screening, assessments, and investigations;

(2) the capacity for local social services agencies to track various financial information, including benefits received by counties on behalf of children in the child welfare system, and fees received by counties from parents with children in out-of-home placements;

(3) access for the ombudspersons for families, the ombudsperson for American Indian families, and the foster youth ombudsperson, on a case-by-case basis, to nonprivileged information necessary for the discharge of the ombudsperson's duties, including specific child protection case information, while protecting Tribal data sovereignty;

(4) comprehensive statewide data reports, including data on law enforcement involvement in the child protection system;

(5) demographic information about children in the child welfare system, including race, cultural and ethnic identity, disability status, and economic status;

(6) bidirectional data exchanges, as required by federal Comprehensive Child Welfare Information System regulations; and

(7) data quality measures, as required by federal Comprehensive Child Welfare Information System regulations.

(b) By March 15, 2026, the commissioner of children, youth, and families must provide the chairs and ranking minority members of the legislative committees with jurisdiction over child welfare and state and local government with a plan and estimated timeline for modernization of the social services information system in compliance with state law and federal Comprehensive Child Welfare Information System requirements.

(c) By August 15, 2026, and by each January 15 and July 15 thereafter, the commissioner must provide an update on the social services information system modernization efforts and progress toward federal compliance required under this section to the chairs and ranking minority members of the legislative committees with jurisdiction over child welfare and state and local government. This paragraph expires upon the commissioner's report to the chairs and ranking minority members of the legislative committees with jurisdiction over child welfare and state and local government that the modernization required under this section has been substantially completed.

ARTICLE 10
EARLY CARE AND LEARNING POLICY

Section 1. Minnesota Statutes 2024, section 142A.42, is amended to read:

142A.42 DIAPER DISTRIBUTION ~~GRANT~~ PROGRAM.

Subdivision 1. **Establishment; purpose.** The commissioner of children, youth, and families shall establish a diaper distribution program to award ~~competitive grants to eligible applicants~~ a sole-source grant to the Diaper Bank of Minnesota to provide diapers to underresourced families statewide.

Subd. 2. **Eligibility.** To be eligible for a grant under this section, ~~an applicant~~ the Diaper Bank of Minnesota must demonstrate its capacity to distribute diapers statewide by having:

(1) a network of well-established partners for diaper distribution;

(2) the infrastructure needed to efficiently manage diaper procurement and distribution statewide;

(3) relationships with national organizations that support and enhance the work of addressing diaper need;

(4) the ability to engage in building community awareness of diaper need and advocate for diaper need at local, state, and federal levels;

(5) a commitment to and demonstration of working with organizations across ideological and political spectrums;

(6) the ability to address diaper need for children from birth through early childhood; and

(7) a commitment to working within an equity framework by ensuring access to organizations that provide culturally specific services or are located in communities with high concentrations of poverty.

Subd. 3. **Application.** ~~Applicants~~ The Diaper Bank of Minnesota must apply to the commissioner in a form and manner prescribed by the commissioner. Applications must be filed at the times and for the periods determined by the commissioner.

Subd. 4. **Eligible uses of grant money.** ~~An eligible applicant that receives grant money under this section shall~~ The Diaper Bank of Minnesota must use the money awarded under this section to purchase diapers and wipes and may use up to ten percent of the money for administrative costs.

Subd. 5. **Enforcement.** (a) ~~An eligible applicant that receives grant money under this section~~ The Diaper Bank of Minnesota must:

(1) retain records documenting expenditure of the grant money;

(2) report to the commissioner on the use of the grant money; and

(3) comply with any additional requirements imposed by the commissioner.

(b) The commissioner may require that a report submitted under this subdivision include an independent audit.

Sec. 2. Minnesota Statutes 2024, section 142D.21, subdivision 6, is amended to read:

Subd. 6. **Payments.** (a) The commissioner shall provide payments under this section to all eligible programs on a noncompetitive basis. The payment amounts shall be based on the number of full-time equivalent staff who regularly care for children in the program, including any employees, sole proprietors, or independent contractors.

(b) For purposes of this section, "one full-time equivalent" is defined as an individual caring for children 32 hours per week. An individual can count as more or less than one full-time equivalent staff, but as no more than two full-time equivalent staff.

(c) The commissioner must establish an amount to award per full-time equivalent individual who regularly cares for children in the program.

~~(d) Payments must be increased by ten percent for programs receiving child care assistance payments under section 142E.08 or 142E.17 or early learning scholarships under section 142D.25, or for programs located in a child care access equity area. The commissioner must develop a method for establishing child care access equity areas. For purposes of this section, "child care access equity area" means an area with low access to child care, high poverty rates, high unemployment rates, low homeownership rates, and low median household incomes.~~

~~(e)~~ (d) The commissioner shall establish the form, frequency, and manner for making payments under this section.

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

Subd. 11. **Data.** (a) For the purposes of this subdivision, the following terms have the meanings given in this paragraph.

(1) "Great start compensation program support payment data" means data for a specified time period showing that a great start compensation payment under this section was made and the amount of great start compensation payments made to a child care and early learning program.

(2) "Data on children and families" means data about the enrollment and attendance as described in subdivision 3, paragraph (a), clause (2).

(b) Great start compensation program support payment data are public except that:

(1) any data on children and families collected by the great start compensation support payment program that may identify a specific family or child or, as determined by the commissioner, are private data on individuals as defined in section 13.02, subdivision 12;

(2) great start compensation payment data about operating expenses and personnel expenses are private or nonpublic data; and

(3) great start compensation payment data about legal nonlicensed child care providers as described in subdivision 8 are private or nonpublic data.

ARTICLE 11
EARLY CARE AND LEARNING FINANCE

Section 1. Minnesota Statutes 2024, section 142B.18, subdivision 4, is amended to read:

Subd. 4. **License suspension, revocation, or fine.** (a) The commissioner may suspend or revoke a license, or impose a fine if:

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

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

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

(4) a license holder is excluded from any program administered by the commissioner under section 142A.12;

(5) revocation is required under section 142B.10, subdivision 14, paragraph (d);

(6) for a family foster setting, a license holder, or an individual living in the household where the licensed services are provided or who is otherwise subject to a background study, has nondisqualifying background study information, as described in section 245C.05, subdivision 4, that reflects on the license holder's ability to safely provide care to foster children; or

(7) suspension is necessary under subdivision 3, paragraph (b), clause (2).

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

(b) If the license was suspended or revoked, the notice must inform the license holder of the right to a contested case hearing under chapter 14 and Minnesota Rules, parts 1400.8505 to 1400.8612. The license holder may appeal an order suspending or revoking a license. The appeal of an order suspending or revoking a license must be made in writing by certified mail, by personal service, or through the provider licensing and reporting hub. If mailed, the appeal must be postmarked and sent to the commissioner within ten calendar days after the license holder receives notice that the license has been suspended or revoked. If a request is made by personal service, it must be received by the commissioner within ten calendar days after the license holder received the order. If the order is issued through the provider hub, the appeal must be received by the commissioner within ten calendar days from the date the commissioner issued the order through the hub. Except as provided in subdivision 3, paragraph (c), if a license holder submits a timely appeal of an order suspending or revoking a license, the license holder may continue to operate the program as provided under section 142B.10, subdivision 14, paragraphs (i) and (j), until the commissioner issues a final order on the suspension or revocation.

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

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

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

(4) Fines shall be assessed as follows:

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

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

(iii) for a program that operates out of the license holder's home and a program licensed under Minnesota Rules, parts 9502.0300 to 9502.0445, the fine assessed against the license holder shall not exceed $1,000 for each determination of maltreatment;

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

(v) the license holder shall forfeit $500 for each occurrence of failure to comply with background study requirements under chapter 245C; and

~~(v)~~ (vi) the license holder shall forfeit $100 for each occurrence of a violation of law or rule other than those subject to a $5,000, $1,000, ~~or~~ $200, or $500 fine in items (i) to ~~(iv)~~ (v).

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

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

Sec. 2. **[142B.68] VIDEO SECURITY CAMERAS IN CHILD CARE CENTERS.**

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

(b) "Facility" means the indoor and outdoor space in which child care is provided that is owned, leased, or operated by a licensed child care center and does not include any outdoor space that is not located on the same property as the licensed child care center.

(c) "Video security camera" means a closed circuit video camera or other closed circuit device that captures or records video.

Subd. 2. **Requirements for video security cameras.** (a) Beginning July 1, 2026, a licensed child care center must have video security cameras in public and shared areas of its facility as provided under this subdivision and comply with the requirements of this section if the center is required to post a maltreatment investigation memorandum under section 142B.16, subdivision 5, or 142B.18, subdivision 6. A center must comply with the requirements under this section within six months of when the maltreatment investigation memorandum is posted and must maintain compliance for the length of time the memorandum is required to be posted.

(b) A licensed child care center must have at least one video security camera in each room designated for infants or toddlers. The camera must be positioned to provide maximum visibility of the room. If one camera is not sufficient to view at least 80 percent of the square footage of the room, the center must place an additional camera or cameras in the room to achieve maximum visibility of the room.

(c) A licensed child care center must have a sufficient number of video security cameras to provide visibility of all the facility's outdoor recreational equipment used by infants or toddlers and at least 80 percent of the square footage of the facility's fenced-in outdoor space used by infants or toddlers.

(d) The video security cameras must:

(1) be turned on and recording at all times the licensed child care center is in operation;

(2) record and display the accurate date and time;

(3) have a display resolution of 720p or higher; and

(4) have a frames per second rate of 15 or higher.

(e) A licensed child care center is exempt from having cameras that meet the requirements under paragraph (d), clauses (2), (3), and (4), if the center has cameras as required in paragraphs (b) and (c) prior to July 1, 2025.

Subd. 3. **Retention and disposal of recordings; access to recordings.** (a) A licensed child care center must retain video security camera recordings for 60 calendar days after the date of the recording. Except as provided under paragraphs (b), (c), and (d), a licensed child care center must dispose of video security camera recordings after 60 calendar days.

(b) A licensed child care center that receives notice from a law enforcement official of a suspected crime committed against a child at the center may not dispose of any video security camera recordings until the law enforcement investigation of the suspected crime is complete.

(c) A licensed child care center must retain video security camera recordings related to an incident that the center must report to the commissioner under Minnesota Rules, part 9503.0130, for six months from the date of the incident.

(d) A licensed child care center may retain video security camera recordings to use for training center employees. Any recordings used for training purposes must redact, as defined under section 13.825, subdivision 1, identifying information on children shown or heard in the recording, unless a parent or legal guardian has provided written consent providing that the center may use unredacted recordings of the parent's or guardian's child.

(e) A licensed child care center must adhere to additional requirements issued by the commissioner regarding retention and disposal of video security camera recordings.

(f) A licensed child care center must establish appropriate security safeguards for video security camera recordings, including procedures for ensuring that the recordings are only accessible to persons whose work assignment reasonably requires access to the recordings, and are only accessed by those persons for purposes described in the procedure. All queries and responses, and all actions in which the recordings are accessed, shared, or disseminated, must be recorded, including the day and time of the action and who was involved in the action. The data created pursuant to this paragraph are subject to the same requirements as the underlying recording under this section.

Subd. 4. **Dissemination of recordings.** (a) A licensed child care center may not sell, share, transmit, or disseminate a video security camera recording to any person except as authorized by this subdivision.

(b) A child care center must disseminate a video security camera recording pursuant to a valid court order, search warrant, or subpoena in a civil, criminal, or administrative proceeding, including an investigation by the commissioner.

(c) A licensed child care center must establish a process by which a parent or legal guardian may review, but not obtain a copy of, a video security camera recording if the parent or guardian provides documentation from a physician of a child's physical injury.

(d) An employee of a licensed child care center who is the subject of proposed disciplinary action by the center based upon evidence obtained by a video security camera must be given access to that evidence for purposes of defending against the proposed action. An employee who obtains a recording or a copy of the recording must treat the recording or copy confidentially and must not further disseminate it to any other person except as required under law. The employee must not keep the recording or copy or a portion of the recording or copy after it is no longer needed for purposes of defending against a proposed action.

Subd. 5. **Exception.** Notwithstanding the requirement to have closed circuit video security cameras under this section and subdivision 4, paragraph (a), a licensed child care center that, as of July 1, 2025, provided remote viewing of video footage for parents and legal guardians may continue to do so in the same manner.

Subd. 6. **Hold harmless.** (a) The commissioner may not issue a fix-it ticket, correction order, or order of conditional license against a child care center license holder for a licensing violation that does not imminently endanger the health or safety of the children served by the center, if the only source of evidence for the violation is video security camera recordings reviewed as part of an investigation under subdivision 4, paragraph (b). This paragraph expires upon implementation of the child care weighted risk system under section 142B.171. The commissioner shall notify the revisor of statutes when the system has been implemented.

(b) Upon implementation of the child care weighted risk system under section 142B.171, the commissioner may not take a licensing action against a child care center license holder for a violation that counts as 6.5 or below for a child care center in the weighted risk system, if the only source of evidence for the violation is video security camera recordings reviewed as part of an investigation under subdivision 4, paragraph (b).

Subd. 7. **Written policy required.** A licensed child care center must have a written policy on the center's use of video security cameras that includes the following:

(1) the days and times the video security cameras in the facility are in use;

(2) the locations of all areas monitored by video security cameras in the facility;

(3) the center's retention and disposal policies and procedures for the video security camera recordings;

(4) the center's policies governing access to the video security camera recordings; and

(5) the center's security safeguards and procedures regarding employee access to the recordings.

Subd. 8. **Notices.** (a) A licensed child care center must notify all parents and legal guardians who apply to enroll or enroll a child in the center about the use of video security cameras in the facility. At the time of a child's enrollment, the center must provide parents and legal guardians with the video security camera policy required under subdivision 7.

(b) A licensed child care center must post a sign at each facility entrance accessible to visitors that states: "Video security cameras are present to record persons and activities."

Subd. 9. **Data practices.** Video footage collected or maintained by the commissioner under this section is classified as welfare data under section 13.46.

Sec. 3. Minnesota Statutes 2024, section 142D.21, subdivision 10, is amended to read:

Subd. 10. **Account; carryforward authority.** ~~Money appropriated under this section is available until expended.~~ (a) An account is established in the special revenue fund known as the great start compensation support payment program account.

(b) Money appropriated under this section must be transferred to the great start compensation support payment program account in the special revenue fund.

(c) Money in the account is annually appropriated to the commissioner for the purposes of this section. Any returned funds are available to be regranted.

Sec. 4. Minnesota Statutes 2024, section 142D.23, subdivision 3, is amended to read:

Subd. 3. **Eligible uses of money.** Grantees must use money received under this section, either directly or through grants to eligible child care providers, for one or more of the following purposes:

(1) the purchase of computers or mobile devices for use in business management;

(2) access to the Internet through the provision of necessary hardware such as routers or modems or by covering the costs of monthly fees for Internet access;

(3) covering the costs of subscription to child care management software;

(4) covering the costs of training in the use of technology for business management purposes; ~~or~~

(5) providing grants for up to $4,000 to licensed child care centers to help cover the costs of video security cameras and related training; or

~~(5)~~ (6) other services as determined by the commissioner.

Sec. 5. Minnesota Statutes 2024, section 142D.31, subdivision 2, is amended to read:

Subd. 2. **Program components.** (a) The nonprofit organization must use the grant for:

(1) tuition scholarships ~~up to $10,000 per year~~ in amounts per year consistent with the national TEACH early childhood program requirements for courses leading to the nationally recognized child development associate credential or college-level courses leading to an associate's degree or bachelor's degree in early childhood development and school-age care; and

(2) education incentives of a minimum of $250 to participants in the tuition scholarship program if they complete a year of working in the early care and education field.

(b) Applicants for the scholarship must be employed by a licensed or certified early childhood or child care program and working directly with children, a licensed family child care provider, employed by a public prekindergarten program, employed by a Head Start program, or an employee in a school-age program exempt from licensing under section 142B.05, subdivision 2, paragraph (a), clause (8). Lower wage earners must be given priority in awarding the tuition scholarships. Scholarship recipients must contribute at least ten percent of the total scholarship and must be sponsored by their employers, who must also contribute at least five percent of the total scholarship. Scholarship recipients who ~~are self-employed~~ work in licensed family child care under Minnesota Rules, chapter 9502, must contribute ~~20~~ at least ten percent of the total scholarship and are not required to receive employer sponsorship or employer match.

Sec. 6. Minnesota Statutes 2024, section 142E.03, subdivision 3, is amended to read:

Subd. 3. **Redeterminations.** (a) Notwithstanding Minnesota Rules, part 3400.0180, item A, the county shall conduct a redetermination according to paragraphs (b) and (c).

(b) The county shall use the redetermination form developed by the commissioner. The county must verify the factors listed in subdivision 1, paragraph (a), as part of the redetermination.

(c) An applicant's eligibility must be redetermined no more frequently than every 12 months. The following criteria apply:

(1) a family meets the eligibility redetermination requirements if a complete redetermination form and all required verifications are received within 30 days after the date the form was due;

(2) if the 30th day after the date the form was due falls on a Saturday, Sunday, or holiday, the 30-day time period is extended to include the next day that is not a Saturday, Sunday, or holiday. Assistance shall be payable retroactively from the redetermination due date;

(3) for a family where at least one parent is younger than 21 years of age, does not have a high school degree or commissioner of education-selected high school equivalency certification, and is a student in a school district or another similar program that provides or arranges for child care, parenting, social services, career and employment supports, and academic support to achieve high school graduation, the redetermination of eligibility may be deferred beyond 12 months, to the end of the student's school year; ~~and~~

(4) starting May 25, 2026, if a new eligible child is added to the family and has care authorized, the redetermination of eligibility must be extended 12 months from the eligible child's arrival date; and

~~(4)~~ (5) a family and the family's providers must be notified that the family's redetermination is due at least 45 days before the end of the family's 12-month eligibility period.

Sec. 7. Minnesota Statutes 2024, section 142E.11, subdivision 1, is amended to read:

Subdivision 1. **General authorization requirements.** (a) When authorizing the amount of child care, the county agency must consider the amount of time the parent reports on the application or redetermination form that the child attends preschool, a Head Start program, or school while the parent is participating in an authorized activity.

(b) Care must be authorized and scheduled with a provider based on the applicant's or participant's verified activity schedule when:

(1) the family requests care from more than one provider per child;

(2) the family requests care from a legal nonlicensed provider; or

(3) an applicant or participant is employed by any child care center that is licensed by the Department of Children, Youth, and Families or has been identified as a high-risk Medicaid-enrolled provider.

This paragraph expires March 2, 2026.

(c) If the family remains eligible at redetermination, a new authorization with fewer hours, the same hours, or increased hours may be determined.

Sec. 8. Minnesota Statutes 2024, section 142E.11, subdivision 2, is amended to read:

Subd. 2. **Maintain steady child care authorizations.** (a) Notwithstanding Minnesota Rules, chapter 3400, the amount of child care authorized under section 142E.12 for employment, education, or an MFIP employment plan shall continue at the same number of hours or more hours until redetermination, including:

(1) when the other parent moves in and is employed or has an education plan under section 142E.12, subdivision 3, or has an MFIP employment plan; or

(2) when the participant's work hours are reduced or a participant temporarily stops working or attending an approved education program. Temporary changes include, but are not limited to, a medical leave, seasonal employment fluctuations, or a school break between semesters.

(b) The county may increase the amount of child care authorized at any time if the participant verifies the need for increased hours for authorized activities.

(c) The county may reduce the amount of child care authorized if a parent requests a reduction or because of a change in:

(1) the child's school schedule;

(2) the custody schedule; or

(3) the provider's availability.

(d) The amount of child care authorized for a family subject to subdivision 1, paragraph (b), must change when the participant's activity schedule changes. Paragraph (a) does not apply to a family subject to subdivision 1, paragraph (b). This paragraph expires March 2, 2026.

(e) When a child reaches 13 years of age or a child with a disability reaches 15 years of age, the amount of child care authorized shall continue at the same number of hours or more hours until redetermination.

Sec. 9. Minnesota Statutes 2024, section 142E.13, subdivision 2, is amended to read:

Subd. 2. **Extended eligibility and redetermination.** (a) If the family received three months of extended eligibility and redetermination is not due, to continue receiving child care assistance the participant must be employed or have an education plan that meets the requirements of section 142E.12, subdivision 3, or have an MFIP employment plan. Notwithstanding Minnesota Rules, part 3400.0110, if child care assistance continues, the amount of child care authorized shall continue at the same number or more hours until redetermination, unless a condition in section 142E.11, subdivision 2, paragraph (c), applies. ~~A family subject to section 142E.11, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.~~

(b) If the family's redetermination occurs before the end of the three-month extended eligibility period to continue receiving child care assistance, the participant must verify that the participant meets eligibility and activity requirements for child care assistance under this chapter. ~~If~~ Notwithstanding Minnesota Rules, part 3400.0110, if child care assistance continues, the amount of child care authorized is based on section 142E.12. ~~A family subject to section 142E.11, subdivision 1, paragraph (b), shall have child care authorized based on a verified activity schedule.~~

EFFECTIVE DATE. This section is effective May 25, 2026.

Sec. 10. Minnesota Statutes 2024, section 142E.15, subdivision 1, is amended to read:

Subdivision 1. **Fee schedule.** All changes to parent fees must be implemented on the first Monday of the service period following the effective date of the change.

PARENT FEE SCHEDULE. The parent fee schedule is as follows, except as noted in subdivision 2:

Income Range (as a percent of the state median income, except at the start of the first tier)	Co-payment (as a percentage of adjusted gross income)
~~0-74.99%~~ 0-99.99% of federal poverty guidelines	$0/biweekly
~~75.00-99.99% of federal poverty guidelines~~	~~$2/biweekly~~
100.00% of federal poverty guidelines- ~~27.72%~~ 27.99%	~~2.61%~~ 2.6%
~~27.73-29.04%~~	~~2.61%~~
~~29.05-30.36%~~	~~2.61%~~
~~30.37-31.68%~~	~~2.61%~~
~~31.69-33.00%~~	~~2.91%~~
~~33.01-34.32%~~	~~2.91%~~
~~34.33-35.65%~~	~~2.91%~~
~~35.66-36.96%~~	~~2.91%~~
~~36.97-38.29%~~	~~3.21%~~
~~38.30-39.61%~~	~~3.21%~~
~~39.62-40.93%~~	~~3.21%~~
~~40.94-42.25%~~	~~3.84%~~
~~42.26-43.57%~~	~~3.84%~~
~~43.58-44.89%~~	~~4.46%~~
~~44.90-46.21%~~	~~4.76%~~
~~46.22-47.53%~~	~~5.05%~~
~~47.54-48.85%~~	~~5.65%~~
~~48.86-50.17%~~	~~5.95%~~

~~50.18-51.49%~~	~~6.24%~~
~~51.50-52.81%~~	~~6.84%~~
~~52.82-54.13%~~	~~7.58%~~
~~54.14-55.45%~~	~~8.33%~~
~~55.46-56.77%~~	~~9.20%~~
~~56.78-58.09%~~	~~10.07%~~
~~58.10-59.41%~~	~~10.94%~~
~~59.42-60.73%~~	~~11.55%~~
~~60.74-62.06%~~	~~12.16%~~
~~62.07-63.38%~~	~~12.77%~~
~~63.39-64.70%~~	~~13.38%~~
~~64.71-67.00%~~	~~14.00%~~
28.00-30.99%	2.6%
31.00-33.99%	2.6%
34.00-36.99%	2.9%
37.00-39.99%	3.2%
40.00-42.99%	3.8%
43.00-45.99%	4.4%
46.00-48.99%	5.0%
49.00-51.99%	5.6%
52.00-54.99%	6.2%
55.00-57.99%	6.8%
58.00-60.99%	6.9%
61.00-63.99%	6.9%
64.00-67.00%	6.9%
Greater than 67.00%	ineligible

A family's biweekly co-payment fee is the fixed percentage established for the income range multiplied by the ~~highest~~ lowest possible income within that income range.

EFFECTIVE DATE. This section is effective October 13, 2025.

Sec. 11. Minnesota Statutes 2024, section 142E.16, subdivision 3, is amended to read:

Subd. 3. **Training required.** (a) Prior to initial authorization as required in subdivision 1, a legal nonlicensed family child care provider must complete first aid and CPR training and provide the verification of first aid and CPR training to the commissioner. The training documentation must have valid effective dates as of the date the registration request is submitted to the commissioner. The training must have been provided by an individual approved to provide first aid and CPR instruction and have included CPR techniques for infants and children.

(b) Upon each reauthorization after the authorization period when the initial first aid and CPR training requirements are met, a legal nonlicensed family child care provider must provide verification of at least eight hours of additional training listed in the Minnesota Center for Professional Development Registry.

(c) Every 12 months, a legal nonlicensed family child care provider who is unrelated to the child they care for must complete two hours of training in caring for children approved by the commissioner.

~~(c)~~ (d) This subdivision only applies to legal nonlicensed family child care providers.

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

Sec. 12. Minnesota Statutes 2024, section 142E.16, subdivision 7, is amended to read:

Subd. 7. **Record-keeping requirement.** (a) As a condition of payment, all providers receiving child care assistance payments must:

(1) keep accurate and legible daily attendance records at the site where services are delivered for children receiving child care assistance; ~~and~~

(2) make those records available immediately to the county or the commissioner upon request. Any records not provided to a county or the commissioner at the date and time of the request are deemed inadmissible if offered as evidence by the provider in any proceeding to contest an overpayment or disqualification of the provider~~.~~; and

(3) submit data on child enrollment and attendance in the form and manner specified by the commissioner.

(b) As a condition of payment, attendance records must be completed daily and include the date, the first and last name of each child in attendance, and the times when each child is dropped off and picked up. To the extent possible, the times that the child was dropped off to and picked up from the child care provider must be entered by the person dropping off or picking up the child. The daily attendance records must be retained at the site where services are delivered for six years after the date of service.

(c) When the county or the commissioner knows or has reason to believe that a current or former provider has not complied with the record-keeping requirement in this subdivision:

(1) the commissioner may:

(i) deny or revoke a provider's authorization to receive child care assistance payments under section 142E.17, subdivision 9, paragraph (d);

(ii) pursue an administrative disqualification under sections 142E.51, subdivision 5, and 256.98; or

(iii) take an action against the provider under ~~sections 142E.50 to 142E.58~~ section 142E.51; or

(2) a county or the commissioner may establish an attendance record overpayment under paragraph (d).

(d) To calculate an attendance record overpayment under this subdivision, the commissioner or county agency shall subtract the maximum daily rate from the total amount paid to a provider for each day that a child's attendance record is missing, unavailable, incomplete, inaccurate, or otherwise inadequate.

(e) The commissioner shall develop criteria for a county to determine an attendance record overpayment under this subdivision.

EFFECTIVE DATE. This section is effective June 22, 2026.

Sec. 13. Minnesota Statutes 2024, section 142E.17, subdivision 9, is amended to read:

Subd. 9. **Provider payments.** (a) A provider shall bill only for services documented according to section 142E.16, subdivision 7. The provider shall bill for services provided within ten days of the end of the service period. A provider must sign each bill and declare, under penalty of perjury as provided in section 609.48, that the information in the bill is true and correct. Payments under the child care fund shall be made within 21 days of receiving a complete bill from the provider. Counties or the state may establish policies that make payments on a more frequent basis.

(b) If a provider has received an authorization of care and been issued a billing form for an eligible family, the bill must be submitted within 60 days of the last date of service on the bill. A bill submitted more than 60 days after the last date of service must be paid if the county determines that the provider has shown good cause why the bill was not submitted within 60 days. Good cause must be defined in the county's child care fund plan under section 142E.09, subdivision 3, and the definition of good cause must include county error. Any bill submitted more than a year after the last date of service on the bill must not be paid.

(c) If a provider provided care for a time period without receiving an authorization of care and a billing form for an eligible family, payment of child care assistance may only be made retroactively for a maximum of three months from the date the provider is issued an authorization of care and a billing form. For a family at application, if a provider provided child care during a time period without receiving an authorization of care and a billing form, a county may only make child care assistance payments to the provider retroactively from the date that child care began, or from the date that the family's eligibility began under section 142E.10, subdivision 7, or from the date that the family meets authorization requirements, not to exceed six months from the date that the provider is issued an authorization of care and a billing form, whichever is later.

(d) The commissioner may refuse to issue a child care authorization to a certified, licensed, or legal nonlicensed provider; revoke an existing child care authorization to a certified, licensed, or legal nonlicensed provider; stop payment issued to a certified, licensed, or legal nonlicensed provider; or refuse to pay a bill submitted by a certified, licensed, or legal nonlicensed provider if:

(1) the provider admits to intentionally giving the county materially false information on the provider's billing forms;

(2) the commissioner finds by a preponderance of the evidence that the provider intentionally gave the county materially false information on the provider's billing forms, or provided false attendance records to a county or the commissioner;

(3) the provider is in violation of child care assistance program rules, until the agency determines those violations have been corrected;

(4) the provider is operating after:

(i) an order of suspension of the provider's license issued by the commissioner;

(ii) an order of revocation of the provider's license issued by the commissioner; or

(iii) an order of decertification issued to the provider;

(5) the provider submits false attendance reports or refuses to provide documentation of the child's attendance upon request;

(6) the provider gives false child care price information; or

(7) the provider fails to report decreases in a child's attendance as required under section 142E.16, subdivision 9.

(e) For purposes of paragraph (d), clauses (3), (5), (6), and (7), the commissioner may withhold the provider's authorization or payment for a period of time not to exceed three months beyond the time the condition has been corrected.

(f) A county's payment policies must be included in the county's child care plan under section 142E.09, subdivision 3. If payments are made by the state, in addition to being in compliance with this subdivision, the payments must be made in compliance with section 16A.124.

(g) If the commissioner suspends or refuses payment to a provider under paragraph (d), clause (1) or (2), or sections 142E.50 to 142E.58 and the provider has:

(1) a disqualification for wrongfully obtaining assistance under section 256.98, subdivision 8, paragraph (c);

(2) an administrative disqualification under section 142E.51, subdivision 5; or

(3) a termination under section 142E.51, subdivision 4, paragraph (c), clause (4), or 142E.55;

then the provider forfeits the payment to the commissioner or the responsible county agency, regardless of the amount assessed in an overpayment, charged in a criminal complaint, or ordered as criminal restitution.

EFFECTIVE DATE. This section is effective September 15, 2025.

Sec. 14. Minnesota Statutes 2024, section 245.0962, subdivision 1, is amended to read:

Subdivision 1. **Establishment.** The commissioner of ~~human services~~ children, youth, and families must establish a quality parenting initiative grant program to implement quality parenting initiative principles and practices to support children and families experiencing foster care placements.

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

Sec. 15. **ELIMINATING SCHEDULE REPORTER DESIGNATION.**

Notwithstanding Minnesota Statutes, section 142E.04, subdivisions 6, 7, and 8, the commissioner of children, youth, and families must allocate additional basic sliding fee child care money for calendar years 2026 and 2027 to counties and Tribes to account for eliminating the schedule reporter designation in the child care assistance program. In allocating the additional money, the commissioner shall consider:

(1) the number of children who are in schedule reporter families; and

(2) the average basic sliding fee cost of care in the county or Tribe.

Sec. 16. **CHILDREN AND FAMILIES INFORMATION TECHNOLOGY SYSTEMS MODERNIZATION.**

Subdivision 1. **Direction to commissioner.** To the extent there is funding available for these purposes in the state systems account established under Minnesota Statutes, section 142A.04, subdivision 2, the commissioner of children, youth, and families must establish and implement the information technology systems described under this section.

Subd. 2. **Family common application tool.** (a) The commissioner must establish and implement an application tool that allows families to apply for available early care and education support programs. The application tool must:

(1) provide integrated support in multiple languages, including real-time translation capabilities;

(2) include an eligibility screener;

(3) include capability for automatic pre-population of known family information and use open authorization to validate identity;

(4) enable application completion and submission across multiple programs and services;

(5) integrate selection tool for early care and education programs;

(6) reach families through various ways, including employers, employee organizations, and medical assistance managed care organizations; and

(7) operate using the software as a service model that ensures frequent maintenance and user experience updates.

(b) Funding under this section for the application tool may only be used for early care and education support programs.

Subd. 3. **Payments system.** The commissioner must establish and implement a centralized, integrated payment system for early care and education funding streams that:

(1) integrates seamlessly with the existing provider licensing and reporting hub;

(2) implements real-time payment processing and cash management capabilities, including instant fund transfers and automated reconciliation;

(3) incorporates robust security measures, including fraud detection and prevention;

(4) enables automated compliance with state and federal reporting requirements;

(5) provides a user-friendly interface with mobile accessibility for child care providers to manage invoices and payments;

(6) ensures interoperability with other relevant state systems and databases; and

(7) implements data quality monitoring and reporting tools to support decision making.

Subd. 4. **Reporting requirements.** The commissioner must provide quarterly implementation updates to the chairs and minority leads of the committees with jurisdiction over programs for children and families. The quarterly updates must describe the department's progress toward establishing and implementing the information technology systems under this section. The quarterly updates must continue until either the systems are fully implemented or the department no longer has sufficient funding for the purposes identified in this section.

Sec. 17. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 245.0962, as Minnesota Statutes, section 142A.47. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

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

Sec. 18. **REVISOR INSTRUCTION.**

The revisor of statutes shall renumber Minnesota Statutes, section 142D.12, subdivision 3, as Minnesota Statutes, section 120B.121. The revisor shall also make necessary cross-reference changes consistent with the renumbering.

ARTICLE 12
DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES
LICENSING AND CERTIFICATION POLICY

Section 1. Minnesota Statutes 2024, section 142B.01, is amended by adding a subdivision to read:

Subd. 12a. **Education.** For purposes of child care centers, "education" means accredited coursework in behavior guidance, child abuse and neglect prevention, child development, child health and safety, child health and wellness, child nutrition, child psychology, child study techniques, children with special needs, communication studies, computer science, coordination of community and school activities, cultural studies, curriculum planning, early childhood education, early childhood special education, elementary education, elementary special education, English language arts, ethics, family studies, history, mathematics, music, parent involvement, psychology, recreational sports, arts and crafts methods or theory, science, social studies, sociology, or other coursework approved by the commissioner.

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

Sec. 2. Minnesota Statutes 2024, section 142B.10, subdivision 14, is amended to read:

Subd. 14. **Grant of license; license extension.** (a) If the commissioner determines that the program complies with all applicable rules and laws, the commissioner shall issue a license consistent with this section or, if applicable, a temporary change of ownership license under section 142B.11. At minimum, the license shall state:

(1) the name of the license holder;

(2) the address of the program;

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

(4) the type of license;

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

(6) any special conditions of licensure.

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

(1) the commissioner is unable to conduct the observation required by subdivision 11, paragraph (a), clause (3), because the program is not yet operational;

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

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

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

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

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

(2) been denied a license under this chapter or chapter 245A within the past two years;

(3) had a license issued under this chapter or chapter 245A revoked within the past five years; or

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

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

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

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

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

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

(i) Pursuant to section 142B.18, subdivision 1, paragraph (b), when a license issued under this chapter has been suspended or revoked and the suspension or revocation is under appeal, the program may continue to operate pending a final order from the commissioner. If the license under suspension or revocation will expire before a final order is issued, a temporary provisional license may be issued provided any applicable license fee is paid before the temporary provisional license is issued.

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

(k) For purposes of reimbursement for meals only, under the Child and Adult Care Food Program, Code of Federal Regulations, title 7, subtitle B, chapter II, subchapter A, part 226, relocation within the same county by a licensed family day care provider, shall be considered an extension of the license for a period of no more than 30 calendar days or until the new license is issued, whichever occurs first, provided the county agency has determined the family day care provider meets licensure requirements at the new location.

(l) Unless otherwise specified by statute, all licenses issued under this chapter expire at 12:01 a.m. on the day after the expiration date stated on the license. A license holder must ~~apply for and be granted~~ comply with the requirements in section 142B.12 and be reissued a new license to operate the program or the program must not be operated after the expiration date. Child foster care license holders must apply for and be granted a new license to operate the program or the program must not be operated after the expiration date. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

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

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

Sec. 3. Minnesota Statutes 2024, section 142B.10, subdivision 16, is amended to read:

Subd. 16. **Variances.** (a) The commissioner may grant variances to rules that do not affect the health or safety of persons in a licensed program if the following conditions are met:

(1) the variance must be requested by an applicant or license holder on a form and in a manner prescribed by the commissioner;

(2) the request for a variance must include the reasons that the applicant or license holder cannot comply with a requirement as stated in the rule and the alternative equivalent measures that the applicant or license holder will follow to comply with the intent of the rule; and

(3) the request must state the period of time for which the variance is requested.

The commissioner may grant a permanent variance when conditions under which the variance is requested do not affect the health or safety of persons being served by the licensed program, nor compromise the qualifications of staff to provide services. The permanent variance shall expire as soon as the conditions that warranted the variance are modified in any way. Any applicant or license holder must inform the commissioner of any changes or modifications that have occurred in the conditions that warranted the permanent variance. Failure to advise the commissioner shall result in revocation of the permanent variance and may be cause for other sanctions under sections 142B.17 and 142B.18.

The commissioner's decision to grant or deny a variance request is final and not subject to appeal under the provisions of chapter 14.

(b) The commissioner shall consider variances for child care center staff qualification requirements under Minnesota Rules, parts 9503.0032 and 9503.0033, that do not affect the health and safety of children served by the center. A variance request must be submitted to the commissioner in accordance with paragraph (a) and must include a plan for the staff person to gain additional experience, education, or training, as requested by the commissioner. When reviewing a variance request under this section, the commissioner shall consider the staff person's level of professional development, including but not limited to steps completed on the Minnesota career lattice.

(c) The commissioner must grant a variance for a child care program's licensed capacity limit if:

(1) the program's indoor space is within 100 square feet of what would be required for maximum capacity in the program based on the program's number and qualifications of staff;

(2) the state fire marshal approves the variance; and

(3) the applicant or license holder submits the variance request to the commissioner in accordance with paragraph (a).

A child care program's licensed capacity must not increase by more than two children under this paragraph. For purposes of this paragraph, a "child care program" means a child care center or family or group family child care provider licensed under this chapter and Minnesota Rules, chapter 9502 or 9503.

~~(c)~~ (d) Counties shall use a uniform application form developed by the commissioner for variance requests by family child care license holders.

Sec. 4. Minnesota Statutes 2024, section 142B.16, subdivision 2, is amended to read:

Subd. 2. **Reconsideration of correction orders.** (a) If the applicant or license holder believes that the contents of the commissioner's correction order are in error, the applicant or license holder may ask the Department of Children, Youth, and Families to reconsider the parts of the correction order that are alleged to be in error. The request for reconsideration must be made in writing and must be postmarked and sent to the commissioner within 20 calendar days after receipt of the correction order under this paragraph, or receipt of the interpretive guidance under paragraph (d), by the applicant or license holder or submitted in the provider licensing and reporting hub within 20 calendar days from the date the commissioner issued the order under this paragraph, or provided the interpretive guidance under paragraph (d), through the hub, and:

(1) specify the parts of the correction order that are alleged to be in error;

(2) explain why they are in error; and

(3) include documentation to support the allegation of error.

(b) Upon implementation of the provider licensing and reporting hub, the provider must use the hub to request reconsideration under this paragraph, or to request interpretive guidance under paragraph (d). A request for reconsideration does not stay any provisions or requirements of the correction order. The commissioner's disposition of a request for reconsideration is final and not subject to appeal under chapter 14.

~~(b)~~ (c) This paragraph applies only to licensed family child care providers. A licensed family child care provider who requests reconsideration of a correction order under paragraph (a) may also request, on a form and in the manner prescribed by the commissioner, that the commissioner expedite the review if:

(1) the provider is challenging a violation and provides a description of how complying with the corrective action for that violation would require the substantial expenditure of funds or a significant change to their program; and

(2) describes what actions the provider will take in lieu of the corrective action ordered to ensure the health and safety of children in care pending the commissioner's review of the correction order.

(d) Prior to a request for reconsideration under paragraph (a), if the applicant or license holder believes that the applicable rule or statute is ambiguous or the commissioner's interpretation of the applicable rule or statute is in error, the applicant or license holder may ask the Department of Children, Youth, and Families to provide interpretive guidance on the applicable rule or statute underlying the correction order.

(e) The commissioner must not publicly post the correction order for licensed child care centers or licensed family child care providers on the department's website until:

(1) after the 20-calendar-day period for requesting reconsideration; or

(2) if the applicant or license holder requested reconsideration, after the commissioner's disposition of a request for reconsideration is provided to the applicant or license holder.

EFFECTIVE DATE. This section is effective July 1, 2025, except that paragraph (e) is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of children, youth, and families must notify the revisor of statutes when federal approval is obtained.

Sec. 5. Minnesota Statutes 2024, section 142B.16, subdivision 5, is amended to read:

Subd. 5. **Requirement to post conditional license.** For licensed family child care providers and child care centers, upon receipt of any order of conditional license issued by the commissioner under this section, and notwithstanding a pending request for reconsideration of the order of conditional license by the license holder, the license holder shall post the order of conditional license in a place that is conspicuous to the people receiving services and all visitors to the facility for two years. When the order of conditional license is accompanied by a maltreatment investigation memorandum prepared under section 626.557 or chapter 260E, the investigation memoranda must be posted with the order of conditional license, and the license holder must post both in a place that is conspicuous to the people receiving services and all visitors to the facility for ten years.

Sec. 6. Minnesota Statutes 2024, section 142B.171, subdivision 2, is amended to read:

Subd. 2. **Documented technical assistance.** (a) In lieu of a correction order under section 142B.16, the commissioner shall provide documented technical assistance to a family child care or child care center license holder if the commissioner finds that:

(1) the license holder has failed to comply with a requirement in this chapter or Minnesota Rules, chapter 9502 or 9503, that the commissioner determines to be low risk as determined by the child care weighted risk system;

(2) the noncompliance does not imminently endanger the health, safety, or rights of the persons served by the program; and

(3) the license holder did not receive documented technical assistance or a correction order for the same violation at the license holder's most recent annual licensing inspection.

(b) Documented technical assistance must include communication from the commissioner to the license holder that:

(1) states the conditions that constitute a violation of a law or rule;

(2) references the specific law or rule violated; and

(3) explains remedies for correcting the violation.

~~(c) The commissioner shall not publicly publish documented technical assistance on the department's website.~~

Sec. 7. Minnesota Statutes 2024, section 142B.18, subdivision 6, is amended to read:

Subd. 6. **Requirement to post licensing order or fine.** For licensed family child care providers and child care centers, upon receipt of any order of license suspension, temporary immediate suspension, fine, or revocation issued by the commissioner under this section, and notwithstanding a pending appeal of the order of license suspension, temporary immediate suspension, fine, or revocation by the license holder, the license holder shall post the order of license suspension, temporary immediate suspension, fine, or revocation in a place that is conspicuous to the people receiving services and all visitors to the facility for two years. When the order of license suspension, temporary immediate suspension, fine, or revocation is accompanied by a maltreatment investigation memorandum prepared under section 626.557 or chapter 260E, the investigation memoranda must be posted with the order of license suspension, temporary immediate suspension, fine, or revocation, and the license holder must post both in a place that is conspicuous to the people receiving services and all visitors to the facility for ten years.

Sec. 8. **[142B.181] POSTING LICENSING ACTIONS ON DEPARTMENT WEBSITE.**

(a) The commissioner must post a summary document for each licensing action, except correction orders under section 142B.16, issued to a licensed child care center and family child care provider on the Licensing Information Lookup public website maintained by the Department of Children, Youth, and Families. The commissioner must not post any communication, including letters, from the commissioner to the center or provider.

(b) The commissioner must remove a summary document from the Licensing Information Lookup public website within ten days of the length of time that the document is required to be posted under Code of Federal Regulations, title 45, section 98.33.

(c) The requirement to post summary documents under this section only applies to licensing actions issued to licensed child care centers and family child care providers after the effective date of this section.

EFFECTIVE DATE. This section is effective January 1, 2026, or upon federal approval, whichever is later. The commissioner of children, youth, and families must notify the revisor of statutes when federal approval is obtained.

Sec. 9. Minnesota Statutes 2024, section 142B.30, subdivision 1, is amended to read:

Subdivision 1. **Delegation of authority to agencies.** (a) County agencies and private agencies that have been designated or licensed by the commissioner to perform licensing functions and activities under section 142B.10; to recommend denial of applicants under section 142B.15; to issue correction orders, to issue variances, and to recommend a conditional license under section 142B.16; or to recommend suspending or revoking a license or issuing a fine under section 142B.18, shall comply with rules and directives of the commissioner governing those functions and with this section. The following variances are excluded from the delegation of variance authority and may be issued only by the commissioner:

(1) dual licensure of family child care and family child foster care;

(2) child foster care maximum age requirement;

(3) variances regarding disqualified individuals;

(4) variances to requirements relating to chemical use problems of a license holder or a household member of a license holder; and

(5) variances to section 142B.74 for a time-limited period. If the commissioner grants a variance under this clause, the license holder must provide notice of the variance to all parents and guardians of the children in care.

(b) The commissioners of human services and children, youth, and families must both approve a variance for dual licensure of family child foster care and family adult foster care or family adult foster care and family child care. Variances under this paragraph are excluded from the delegation of variance authority and may be issued only by both commissioners.

(c) Except as provided in section 142B.41, subdivision 4, paragraph (e), a county agency must not grant a license holder a variance to exceed the maximum allowable family child care license capacity of 14 children.

(d) A county agency that has been designated by the commissioner to issue family child care variances must:

(1) publish the county agency's policies and criteria for issuing variances on the county's public website and update the policies as necessary; and

(2) annually distribute the county agency's policies and criteria for issuing variances to all family child care license holders in the county.

(e) Before the implementation of NETStudy 2.0, county agencies must report information about disqualification reconsiderations under sections 245C.25 and 245C.27, subdivision 2, paragraphs (a) and (b), and variances granted under paragraph (a), clause (5), to the commissioner at least monthly in a format prescribed by the commissioner.

(f) For family child care programs, the commissioner shall require a county agency to conduct one unannounced licensing review at least annually.

(g) A child foster care license issued under this section may be issued for up to two years until implementation of the provider licensing and reporting hub. Upon implementation of the provider licensing and reporting hub, licenses may be issued each calendar year.

(h) A county agency shall report to the commissioner, in a manner prescribed by the commissioner, the following information for a licensed family child care program:

(1) the results of each licensing review completed, including the date of the review, and any licensing correction order issued;

(2) any death, serious injury, or determination of substantiated maltreatment; and

(3) any fires that require the service of a fire department within 48 hours of the fire. The information under this clause must also be reported to the state fire marshal within two business days of receiving notice from a licensed family child care provider.

Sec. 10. Minnesota Statutes 2024, section 142B.41, is amended by adding a subdivision to read:

Subd. 7a. **Staff distribution.** Notwithstanding Minnesota Rules, part 9503.0040, subpart 2, item B, an aide may substitute for a teacher during morning arrival and afternoon departure times in a licensed child care center if the total arrival and departure time does not exceed 25 percent of the center's daily hours of operation. In order for an aide to be used in this capacity, an aide must:

(1) be at least 18 years of age;

(2) have worked in the licensed child care center for a minimum of 30 days; and

(3) have completed all preservice and first-90-days training required for licensing.

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

Sec. 11. Minnesota Statutes 2024, section 142B.51, subdivision 2, is amended to read:

Subd. 2. **Child passenger restraint systems; training requirement.** (a) Programs licensed by the Department of Human Services under chapter 245A or the Department of Children, Youth, and Families under this chapter and Minnesota Rules, chapter 2960, that serve a child or children under ~~eight~~ nine years of age must document training that fulfills the requirements in this subdivision.

(b) Before a license holder, staff person, or caregiver transports a child or children under age ~~eight~~ nine in a motor vehicle, the person transporting the child must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this section may be used to meet initial or ongoing training under Minnesota Rules, part 2960.3070, subparts 1 and 2.

(c) Training required under this section must be completed at orientation or initial training and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(d) Training under paragraph (c) must be provided by individuals who are certified and approved by the Office of Traffic Safety within the Department of Public Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

~~(e) Notwithstanding paragraph (a), for an emergency relative placement under section 142B.06, the commissioner may grant a variance to the training required by this subdivision for a relative who completes a child seat safety check up. The child seat safety check up trainer must be approved by the Department of Public Safety, Office of Traffic Safety, and must provide one on one instruction on placing a child of a specific age in the exact child passenger restraint in the motor vehicle in which the child will be transported. Once granted a variance, and if all other licensing requirements are met, the relative applicant may receive a license and may transport a relative foster child younger than eight years of age. A child seat safety check up must be completed each time a child requires a different size car seat according to car seat and vehicle manufacturer guidelines. A relative license holder must complete training that meets the other requirements of this subdivision prior to placement of another foster child younger than eight years of age in the home or prior to the renewal of the child foster care license.~~

EFFECTIVE DATE. This section is effective January 1, 2026, except paragraph (e), which is effective July 1, 2026.

Sec. 12. Minnesota Statutes 2024, section 142B.65, subdivision 8, is amended to read:

Subd. 8. **Child passenger restraint systems; training requirement.** (a) Before a license holder transports a child or children under age ~~eight~~ nine in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles.

(b) Training required under this subdivision must be repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(c) Training required under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

(d) Child care providers that only transport school-age children as defined in section 142B.01, subdivision 25, in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

(e) Training completed under this subdivision may be used to meet in-service training requirements under subdivision 9. Training completed within the previous five years is transferable upon a staff person's change in employment to another child care center.

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

Sec. 13. Minnesota Statutes 2024, section 142B.65, subdivision 9, is amended to read:

Subd. 9. **In-service training.** (a) A license holder must ensure that the center director, staff persons, substitutes, and unsupervised volunteers complete in-service training each calendar year.

(b) The center director and staff persons who work more than 20 hours per week must complete 24 hours of in-service training each calendar year. Staff persons who work 20 hours or less per week must complete 12 hours of in-service training each calendar year. Substitutes and unsupervised volunteers must complete at least two hours of training each year, and the training must include the requirements of paragraphs (d) to (g) ~~and do not otherwise have a minimum number of hours of training to complete~~.

(c) The number of in-service training hours may be prorated for ~~individuals~~ center directors and staff persons not employed for an entire year.

(d) Each year, in-service training must include:

(1) the center's procedures for maintaining health and safety according to section 142B.66 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according to Minnesota Rules, part 9503.0110;

(2) the reporting responsibilities under chapter 260E and Minnesota Rules, part 9503.0130;

(3) at least one-half hour of training on the standards under section 142B.46 and on reducing the risk of sudden unexpected infant death as required under subdivision 6, if applicable; and

(4) at least one-half hour of training on the risk of abusive head trauma from shaking infants and young children as required under subdivision 7, if applicable.

(e) Each year, or when a change is made, whichever is more frequent, in-service training must be provided on: (1) the center's risk reduction plan under section 142B.54, subdivision 2; and (2) a child's individual child care program plan as required under Minnesota Rules, part 9503.0065, subpart 3.

(f) At least once every two calendar years, the in-service training must include:

(1) child development and learning training under subdivision 3;

(2) pediatric first aid that meets the requirements of subdivision 4;

(3) pediatric cardiopulmonary resuscitation training that meets the requirements of subdivision 5;

(4) cultural dynamics training to increase awareness of cultural differences; and

(5) disabilities training to increase awareness of differing abilities of children.

(g) At least once every five years, in-service training must include child passenger restraint training that meets the requirements of subdivision 8, if applicable.

(h) The remaining hours of the in-service training requirement must be met by completing training in the following content areas of the Minnesota Knowledge and Competency Framework:

(1) Content area I: child development and learning;

(2) Content area II: developmentally appropriate learning experiences;

(3) Content area III: relationships with families;

(4) Content area IV: assessment, evaluation, and individualization;

(5) Content area V: historical and contemporary development of early childhood education;

(6) Content area VI: professionalism;

(7) Content area VII: health, safety, and nutrition; and

(8) Content area VIII: application through clinical experiences.

(i) For purposes of this subdivision, the following terms have the meanings given them.

(1) "Child development and learning training" means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community.

(2) "Developmentally appropriate learning experiences" means creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, and promoting creative development.

(3) "Relationships with families" means training on building a positive, respectful relationship with the child's family.

(4) "Assessment, evaluation, and individualization" means training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality.

(5) "Historical and contemporary development of early childhood education" means training in past and current practices in early childhood education and how current events and issues affect children, families, and programs.

(6) "Professionalism" means training in knowledge, skills, and abilities that promote ongoing professional development.

(7) "Health, safety, and nutrition" means training in establishing health practices, ensuring safety, and providing healthy nutrition.

(8) "Application through clinical experiences" means clinical experiences in which a person applies effective teaching practices using a range of educational programming models.

(j) The license holder must ensure that documentation, as required in subdivision 10, includes the number of total training hours required to be completed, name of the training, the Minnesota Knowledge and Competency Framework content area, number of hours completed, and the director's approval of the training.

(k) In-service training completed by a staff person that is not specific to that child care center is transferable upon a staff person's change in employment to another child care program.

Sec. 14. Minnesota Statutes 2024, section 142B.66, subdivision 3, is amended to read:

Subd. 3. **Emergency preparedness.** (a) A licensed child care center must have a written emergency plan for emergencies that require evacuation, sheltering, or other protection of a child, such as fire, natural disaster, intruder, or other threatening situation that may pose a health or safety hazard to a child. The plan must be written on a form developed by the commissioner and must include:

(1) procedures for an evacuation, relocation, shelter-in-place, or lockdown;

(2) a designated relocation site and evacuation route;

(3) procedures for notifying a child's parent or legal guardian of the evacuation, relocation, shelter-in-place, or lockdown, including procedures for reunification with families;

(4) accommodations for a child with a disability or a chronic medical condition;

(5) procedures for storing a child's medically necessary medicine that facilitates easy removal during an evacuation or relocation;

(6) procedures for continuing operations in the period during and after a crisis;

(7) procedures for communicating with local emergency management officials, law enforcement officials, or other appropriate state or local authorities; and

(8) accommodations for infants and toddlers.

(b) The license holder must train staff persons on the emergency plan at orientation, when changes are made to the plan, and at least once each calendar year. Training must be documented in each staff person's personnel file.

(c) The license holder must conduct drills according to the requirements in Minnesota Rules, part 9503.0110, subpart 3. The date and time of the drills must be documented.

(d) The license holder must review and update the emergency plan ~~annually~~ each calendar year. Documentation of the ~~annual~~ yearly emergency plan review shall be maintained in the program's administrative records.

(e) The license holder must include the emergency plan in the program's policies and procedures as specified under section 142B.10, subdivision 21. The license holder must provide a physical or electronic copy of the emergency plan to the child's parent or legal guardian upon enrollment.

(f) The relocation site and evacuation route must be posted in a visible place as part of the written procedures for emergencies and accidents in Minnesota Rules, part 9503.0140, subpart 21.

Sec. 15. Minnesota Statutes 2024, section 142B.70, subdivision 7, is amended to read:

Subd. 7. **Child passenger restraint systems; training requirement.** (a) A license holder must comply with all seat belt and child passenger restraint system requirements under section 169.685.

(b) Family and group family child care programs licensed by the Department of Children, Youth, and Families that serve a child or children under ~~eight~~ nine years of age must document training that fulfills the requirements in this subdivision.

(1) Before a license holder, second adult caregiver, substitute, or helper transports a child or children under age ~~eight~~ nine in a motor vehicle, the person placing the child or children in a passenger restraint must satisfactorily complete training on the proper use and installation of child restraint systems in motor vehicles. Training completed under this subdivision may be used to meet initial training under subdivision 1 or ongoing training under subdivision 8.

(2) Training required under this subdivision must be at least one hour in length, completed at initial training, and repeated at least once every five years. At a minimum, the training must address the proper use of child restraint systems based on the child's size, weight, and age, and the proper installation of a car seat or booster seat in the motor vehicle used by the license holder to transport the child or children.

(3) Training under this subdivision must be provided by individuals who are certified and approved by the Department of Public Safety, Office of Traffic Safety. License holders may obtain a list of certified and approved trainers through the Department of Public Safety website or by contacting the agency.

(c) Child care providers that only transport school-age children as defined in section 142B.01, subdivision 13, paragraph (f), in child care buses as defined in section 169.448, subdivision 1, paragraph (e), are exempt from this subdivision.

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

Sec. 16. Minnesota Statutes 2024, section 142B.70, subdivision 8, is amended to read:

Subd. 8. **Training requirements for family and group family child care.** (a) For purposes of family and group family child care, the license holder and each second adult caregiver must complete 16 hours of ongoing training each year. Repeat of topical training requirements in subdivisions 3 to 9 shall count toward the annual 16-hour training requirement. Additional ongoing training subjects to meet the annual 16-hour training requirement must be selected from the following areas:

(1) child development and learning training in understanding how a child develops physically, cognitively, emotionally, and socially, and how a child learns as part of the child's family, culture, and community;

(2) developmentally appropriate learning experiences, including training in creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, promoting creative development; and behavior guidance;

(3) relationships with families, including training in building a positive, respectful relationship with the child's family;

(4) assessment, evaluation, and individualization, including training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality;

(5) historical and contemporary development of early childhood education, including training in past and current practices in early childhood education and how current events and issues affect children, families, and programs;

(6) professionalism, including training in knowledge, skills, and abilities that promote ongoing professional development; and

(7) health, safety, and nutrition, including training in establishing healthy practices; ensuring safety; and providing healthy nutrition.

(b) A provider who is approved as a trainer through the Develop data system may count up to two hours of training instruction toward the annual 16-hour training requirement in paragraph (a). The provider may only count training instruction hours for the first instance in which they deliver a particular content-specific training during each licensing year. Hours counted as training instruction must be approved through the Develop data system with attendance verified on the trainer's individual learning record and must be in Knowledge and Competency Framework content area VII A (Establishing Healthy Practices) or B (Ensuring Safety).

(c) Substitutes and adult caregivers who provide care for 500 or fewer hours per year must complete a minimum of one hour of training each calendar year, and the training must include the requirements in subdivisions 3, 4, 5, 6, and 9.

Sec. 17. Minnesota Statutes 2024, section 142B.77, is amended to read:

142B.77 ~~SUPERVISION OF~~ REQUIREMENTS FOR FAMILY CHILD CARE LICENSE HOLDER'S OWN CHILD.

Subdivision 1. **Supervision of license holder's own child.** (a) Notwithstanding Minnesota Rules, part 9502.0365, subpart 5, and with the license holder's consent, an individual may be present in the licensed space, may supervise the family child care license holder's own child both inside and outside of the licensed space, and is exempt from the training and supervision requirements of this chapter and Minnesota Rules, chapter 9502, if the individual:

(1) is related to the license holder or to the license holder's child, as defined in section 142B.01, subdivision 15, or is a household member who the license holder has reported to the county agency;

(2) is not a designated caregiver, helper, or substitute for the licensed program;

(3) is involved only in the care of the license holder's own child; and

(4) does not have direct, unsupervised contact with any nonrelative children receiving services.

(b) If the individual in paragraph (a) is not a household member, the individual is also exempt from background study requirements under chapter 245C.

Subd. 2. **Exclusion from licensed capacity.** For the purposes of licensed capacity requirements under Minnesota Rules, part 9502.0367, one of a license holder's own children is excluded from licensed capacity, provided the excluded child is at least eight years old and the license holder has never been determined to have maltreated a child or vulnerable adult under section 626.557 or chapter 260E.

Sec. 18. Minnesota Statutes 2024, section 142C.06, is amended by adding a subdivision to read:

Subd. 4. **Requirement to post conditional certification.** Upon receipt of any order of conditional certification issued by the commissioner under this section, and notwithstanding a pending request for reconsideration of the order of conditional certification by the certification holder, the certification holder shall post the order of conditional certification in a place that is conspicuous to the people receiving services and all visitors to the facility for the duration of the conditional certification. When the order of conditional certification is accompanied by a maltreatment investigation memorandum prepared under chapter 260E, the investigation memoranda must be posted with the order of conditional certification.

Sec. 19. Minnesota Statutes 2024, section 142C.11, subdivision 8, is amended to read:

Subd. 8. **Required policies.** A certified center must have written policies for health and safety items in subdivisions 1 to 6, 9, and 10.

Sec. 20. Minnesota Statutes 2024, section 142C.12, subdivision 1, is amended to read:

Subdivision 1. **First aid and cardiopulmonary resuscitation.** (a) Before having unsupervised direct contact with a child, but within 90 days after the first date of direct contact with a child, the director, all staff persons, substitutes, and unsupervised volunteers must successfully complete pediatric first aid and pediatric cardiopulmonary resuscitation (CPR) training, unless the training has been completed within the previous two calendar years. Staff must complete the pediatric first aid and pediatric CPR training at least every other calendar year and the center must document the training in the staff person's personnel record.

(b) Training completed under this subdivision may be used to meet the in-service training requirements under subdivision 6.

(c) Training must include CPR and techniques for providing immediate care to people experiencing life-threatening cardiac emergencies, choking, bleeding, fractures and sprains, head injuries, poisoning, and burns. Training developed by the American Heart Association, the American Red Cross, or another organization that uses nationally recognized, evidence-based guidelines meets these requirements.

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

Sec. 21. Minnesota Statutes 2024, section 142C.12, subdivision 6, is amended to read:

Subd. 6. **In-service training.** (a) The certified center must ensure that the director and all staff persons, including substitutes and unsupervised volunteers, are trained at least once each calendar year on health and safety requirements in this section and sections 142C.10, 142C.11, and 142C.13.

(b) The director and each staff person, not including substitutes, must complete at least six hours of training each calendar year. Substitutes must complete at least two hours of training each calendar year. Training required under paragraph (a) may be used toward the hourly training requirements of this subdivision.

Sec. 22. Minnesota Statutes 2024, section 245A.18, subdivision 1, is amended to read:

Subdivision 1. **Seat belt and child passenger restraint system use.** All license holders that transport children must comply with the requirements of section 142B.51, subdivision 1, and license holders that transport a child or children under ~~eight~~ nine years of age must document training that fulfills the requirements in section 142B.51, subdivision 2.

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

Sec. 23. **DIRECTION TO COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES; STANDARDIZED LICENSING VISIT TIMELINE AND REQUIREMENTS.**

(a) The commissioner of children, youth, and families must, in consultation with stakeholders, develop and implement a standardized timeline and standards for the conduct of licensors when conducting inspections of licensed child care centers. The timeline and standards developed by the commissioner must clearly identify:

(1) the steps of a licensing visit;

(2) the expectations for licensors and license holders before, during, and after the licensing visit;

(3) the standards of conduct that licensors must follow during a visit;

(4) the rights of license holders;

(5) when and how license holders can request technical assistance; and

(6) a process for license holders to request additional review of an issue related to the licensing visit from someone other than the assigned licensor.

(b) The timeline and standards must be implemented by January 1, 2026.

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

Sec. 24. **DIRECTION TO COMMISSIONER OF CHILDREN, YOUTH, AND FAMILIES; STANDARDIZED COUNTY-DELEGATED LICENSING.**

By January 1, 2026, the commissioner of children, youth, and families must:

(1) establish time frames for county licensors to respond to time-sensitive or urgent requests and implement a system to track response times to the requests; and

(2) require county licensors to use the electronic licensing inspection tool during an inspection of a family child care provider and to complete the inspection report on site with the license holder, including direct communication related to any correction orders issued.

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

Sec. 25. **REPEALER.**

Minnesota Rules, part 9503.0030, subpart 1, item B, is repealed.

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

ARTICLE 13
MISCELLANEOUS

Section 1. **[135A.1367] OPIATE ANTAGONIST.**

Subdivision 1. **Definition.** For purposes of this section, "opiate antagonist" has the meaning given in section 604A.04, subdivision 1.

Subd. 2. **Minnesota State Colleges and Universities; University of Minnesota.** (a) The Board of Trustees of the Minnesota State Colleges and Universities shall, and the Board of Regents of the University of Minnesota is requested to:

(1) maintain a supply of opiate antagonists at each campus site to be administered in compliance with section 151.37, subdivision 12; and

(2) have at least two doses of a nasal opiate antagonist available on site at each campus residential building.

(b) The commissioner of health shall identify resources, including at least one training video, to help postsecondary institutions implement an opiate antagonist emergency response and make the resources available for institutions.

(c) The Board of Trustees and the Board of Regents may adopt a model plan for use, storage, and administration of opiate antagonists on system campuses.

Subd. 3. **Tribal colleges.** (a) The commissioner of health shall distribute money to Leech Lake Tribal College, White Earth Tribal College, and Red Lake Nation Tribal College to make opiate antagonists available according to paragraph (b). The commissioner may determine an appropriate method to equitably allocate the amounts appropriated among the colleges.

(b) A Tribal college receiving money under this section must:

(1) maintain a supply of opiate antagonists at each campus site to be administered in compliance with section 151.37, subdivision 12; and

(2) have at least two doses of a nasal opiate antagonist available on site at each campus residential building.

EFFECTIVE DATE. This section is effective beginning in the 2025-2026 academic year.

Sec. 2. Minnesota Statutes 2024, section 145C.01, is amended by adding a subdivision to read:

Subd. 1c. **Emergency medical services provider.** "Emergency medical services provider" means:

(1) an ambulance service licensed under chapter 144E;

(2) a medical response unit as defined in section 144E.275, subdivision 1;

(3) an emergency medical responder as defined in section 144E.001, subdivision 6; or

(4) ambulance service personnel as defined in section 144E.001, subdivision 3a.

Sec. 3. Minnesota Statutes 2024, section 145C.01, is amended by adding a subdivision to read:

Subd. 7b. **Nonopioid directive.** "Nonopioid directive" means a written instrument that includes one or more instructions that a patient must not be administered an opioid by a health professional or be offered a prescription for an opioid by a prescriber.

Sec. 4. Minnesota Statutes 2024, section 145C.01, is amended by adding a subdivision to read:

Subd. 7c. **Prescriber.** "Prescriber" means an individual who is authorized by section 148.235; 151.01, subdivision 23; or 151.37 to prescribe prescription drugs.

Sec. 5. Minnesota Statutes 2024, section 145C.17, is amended to read:

145C.17 OPIOID INSTRUCTIONS ENTERED INTO HEALTH RECORD.

At the request of the patient or health care agent, a health care provider shall enter into the patient's health care record any instructions relating to administering, dispensing, or prescribing an opioid. A health care provider presented with a nonopioid directive executed by or on behalf of a patient must include the nonopioid directive in the patient's health care record. A health care provider receiving notice of revocation of a patient's nonopioid directive must note the revocation in the patient's health care record.

Sec. 6. **[145C.18] NONOPIOID DIRECTIVE.**

Subdivision 1. **Execution.** A patient with the capacity to do so may execute a nonopioid directive on the patient's own behalf. A patient's health care agent may execute a nonopioid directive on behalf of the patient. A nonopioid directive must include one or more instructions that the patient must not be administered an opioid by a health professional or be offered a prescription for an opioid by a prescriber.

Subd. 2. **Revocation.** A patient who executed a nonopioid directive on the patient's own behalf may revoke the nonopioid directive at any time and in any manner in which the patient is able to communicate an intent to revoke the nonopioid directive. A patient's health care agent may revoke the nonopioid directive executed on behalf of a patient by executing a written, dated statement of revocation and by providing notice of the revocation to the patient's health care provider.

Subd. 3. **Compliance with nonopioid directive; exception.** (a) Except as specified in paragraph (b), prescribers and health professionals must comply with a nonopioid directive executed under this section.

(b) A prescriber or a health professional acting on the order of a prescriber may administer an opioid to a patient with a nonopioid directive if:

(1) the patient is being treated, in emergency circumstances, in a hospital setting or in a setting outside a hospital;

(2) in the prescriber's professional opinion, it is medically necessary to administer an opioid to the patient in order to treat the patient, including but not limited to during a surgical procedure when one or more complications arise; and

(3) it is not practical or feasible for the prescriber or health professional to access the patient's health care record.

If an opioid is administered according to this paragraph to a patient with a nonopioid directive, the prescriber must ensure that the patient is provided with information on substance use disorder services.

Subd. 4. **Immunities.** Except as otherwise provided by law, the following persons or entities are not subject to criminal prosecution, civil liability, or professional disciplinary action for failing to prescribe, administer, or dispense an opioid to a patient with a nonopioid directive; for the administration of an opioid in the circumstances in subdivision 3, paragraph (b), to a patient with a nonopioid directive; or for the inadvertent administration of an opioid to a patient with a nonopioid directive, if the act or failure to act was performed in good faith and in accordance with the applicable standard of care:

(1) a health professional whose scope of practice includes prescribing, administering, or dispensing a controlled substance;

(2) an employee of a health professional described in clause (1);

(3) a health care facility or an employee of a health care facility; or

(4) an emergency medical services provider.

Subd. 5. **Nonopioid directive form.** The commissioner of health must develop a nonopioid directive form for use by patients and health care agents to communicate to health professionals and prescribers that a patient with a nonopioid directive must not be administered an opioid or offered a prescription for an opioid. The commissioner must include on the nonopioid directive form instructions for how to revoke a nonopioid directive and other information the commissioner deems relevant. The commissioner must post the form on the Department of Health website.

Sec. 7. Minnesota Statutes 2024, section 151.37, subdivision 12, is amended to read:

Subd. 12. **Administration of opiate antagonists for drug overdose.** (a) A licensed physician, a licensed advanced practice registered nurse authorized to prescribe drugs pursuant to section 148.235, or a licensed physician assistant may authorize the following individuals to administer opiate antagonists, as defined in section 604A.04, subdivision 1:

(1) an emergency medical responder registered pursuant to section 144E.27;

(2) a peace officer as defined in section 626.84, subdivision 1, paragraphs (c) and (d);

(3) correctional employees of a state or local political subdivision;

(4) staff of community-based health disease prevention or social service programs;

(5) a volunteer firefighter;

(6) a nurse or any other personnel employed by, or under contract with, a postsecondary institution or a charter, public, or private school; and

(7) transit rider investment program personnel authorized under section 473.4075.

(b) For the purposes of this subdivision, opiate antagonists may be administered by one of these individuals only if:

(1) the licensed physician, licensed physician assistant, or licensed advanced practice registered nurse has issued a standing order to, or entered into a protocol with, the individual; and

(2) the individual has training in the recognition of signs of opiate overdose and the use of opiate antagonists as part of the emergency response to opiate overdose.

(c) Nothing in this section prohibits the possession and administration of naloxone pursuant to section 604A.04.

(d) Notwithstanding section 148.235, subdivisions 8 and 9, a licensed practical nurse is authorized to possess and administer according to this subdivision an opiate antagonist in a school setting.

Sec. 8. **[325M.335] MENTAL HEALTH WARNING LABEL.**

Subdivision 1. **Warning label required.** (a) A social media platform must ensure that a conspicuous mental health warning label that complies with the requirements under this section:

(1) appears each time a user accesses the social media platform; and

(2) only disappears when the user: (i) exits the social media platform; or (ii) acknowledges the potential for harm and chooses to proceed to the social media platform despite the risk.

(b) A mental health warning label under this section must:

(1) in a manner that conforms with the guidelines established under subdivision 2, warn the user of potential negative mental health impacts of accessing the social media platform; and

(2) provide the user access to resources to address the potential negative mental health impacts described in clause (1) and include the website and telephone number of a national suicide prevention and mental health crisis hotline system, including but not limited to the 988 Suicide and Crisis Lifeline.

(c) A social media platform is prohibited from:

(1) providing the warning label exclusively in the social media platform's terms and conditions;

(2) including extraneous information in the warning label that obscures the visibility or prominence of the warning label; or

(3) allowing a user to disable a warning label, except as provided under paragraph (a).

Subd. 2. **Content of label.** (a) The commissioner of health, in consultation with the commissioner of commerce, must develop guidelines for social media platforms that contain appropriate requirements for the warning labels required under this section. The guidelines must be based on current evidence regarding the negative mental health impacts of social media platforms. The commissioners must review and revise the guidelines as appropriate.

(b) The commissioner of health is exempt from chapter 14, including section 14.386, when implementing this subdivision.

Sec. 9. Minnesota Statutes 2024, section 325M.34, is amended to read:

325M.34 ENFORCEMENT AUTHORITY.

(a) The attorney general may investigate and bring an action against a social media platform for an alleged violation of section 325M.33 or 325M.335.

(b) Nothing in sections 325M.30 to 325M.34 creates a private cause of action in favor of a person injured by a violation of section 325M.33.

ARTICLE 14
DEPARTMENT OF HUMAN SERVICES APPROPRIATIONS

Section 1. **HUMAN SERVICES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the commissioner of human services for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **COMMISSIONER OF HUMAN SERVICES**	**$2,865,274,000**	**$2,954,109,000**

Subdivision 1. **Total Appropriation**

Appropriations by Fund	2026	2027
General	1,583,167,000	1,795,471,000
Health Care Access	1,282,107,000	1,158,634,000

The amounts that may be spent for each purpose are specified in this article.

Subd. 2. **Information Technology Appropriations**

(a) **IT appropriations generally.** This appropriation includes money for information technology projects, services, and support. Funding for information technology project costs must be incorporated into the service-level agreement and paid to Minnesota IT Services by the Department of Human Services under the rates and mechanism specified in that agreement.

(b) **Receipts for systems project.** Appropriations and federal receipts for information technology systems projects for MMIS and METS must be deposited in the state systems account authorized in Minnesota Statutes, section 256.014. Money appropriated for information technology projects approved by the commissioner of Minnesota IT Services, funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of human services deems necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Sec. 3. **CENTRAL OFFICE; OPERATIONS**

Subdivision 1. **Total Appropriation**	**$232,000**	**$232,000**

Subd. 2. **Base Level Adjustment**

The base for this section is $75,000 in fiscal year 2028 and $75,000 in fiscal year 2029.

Sec. 4. **CENTRAL OFFICE; HEALTH CARE**

Subdivision 1. **Total Appropriation**	**$3,964,000**	**$24,131,000**

Subd. 2. **Base Level Adjustment**

The base for this section is $44,158,000 in fiscal year 2028 and $44,158,000 in fiscal year 2029.

Sec. 5. **CENTRAL OFFICE; BEHAVIORAL HEALTH**

Subdivision 1. **Total Appropriation**	**$-0-**	**$741,000**

Subd. 2. **Base Level Adjustment**

The base for this section is $768,000 in fiscal year 2028 and $768,000 in fiscal year 2029.

Sec. 6. **FORECASTED PROGRAMS; MEDICAL ASSISTANCE**

Subdivision 1. **Total Appropriation** **$2,852,802,000** **$2,920,843,000**

Appropriations by Fund

General	1,574,160,000	1,765,674,000
Health Care Access	1,278,642,000	1,155,169,000

Subd. 2. **Base Level Adjustment**

The health care access fund base for this section is $1,157,833,000 in fiscal year 2028 and $1,176,922,000 in fiscal year 2029.

Sec. 7. **FORECASTED PROGRAMS; BEHAVIORAL HEALTH FUND** **$-0-** **$39,000**

Sec. 8. **GRANT PROGRAMS; HEALTH CARE GRANTS** **$8,276,000** **$8,276,000**

Appropriations by Fund

General	4,811,000	4,811,000
Health Care Access	3,465,000	3,465,000

Sec. 9. **TRANSFERS.**

Subdivision 1. **Grants.** The commissioner of human services, with the advance approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2027, within fiscal years among general assistance, medical assistance, MinnesotaCare, the Minnesota supplemental aid program, the housing support program, and the entitlement portion of the behavioral health fund between fiscal years of the biennium. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Human Services as the commissioner deems necessary, with the advance approval of the commissioner of management and budget. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance quarterly about transfers made under this section.

Sec. 10. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 11. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, cancellation, or transfer in this article is enacted more than once during the 2025 regular session, the appropriation, cancellation, or transfer must be given effect once.

Sec. 12. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires June 30, 2027, unless a different expiration date is explicit or an appropriation is made available beyond June 30, 2027.

ARTICLE 15
DEPARTMENT OF HEALTH APPROPRIATIONS

Section 1. **HEALTH APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the commissioner of health for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **COMMISSIONER OF HEALTH**	**$413,039,000**	**$410,410,000**

Appropriations by Fund

	2026	2027
General	265,883,000	264,366,000
State Government Special Revenue	80,678,000	80,512,000
Health Care Access	54,765,000	53,819,000
Federal TANF	11,713,000	11,713,000

The amounts that may be spent for each purpose are specified in this article.

Sec. 3. **HEALTH IMPROVEMENT**

Subdivision 1. **Total Appropriation**	**$285,240,000**	**$280,679,000**

Appropriations by Fund

General	210,915,000	208,746,000
State Government Special Revenue	9,258,000	9,258,000
Health Care Access	53,354,000	50,962,000
Federal TANF	11,713,000	11,713,000

Subd. 2. **Local and Tribal Public Health Cannabis and Substance Misuse Grant Program**

$6,256,000 in fiscal year 2026 and $6,256,000 in fiscal year 2027 are from the general fund for the local and Tribal public health cannabis and substance misuse grant program under Minnesota Statutes, section 144.197, subdivision 4.

Subd. 3. **Cannabis and Substance Misuse Prevention and Education Programs; Youth Prevention and Education Program**

$4,876,000 in fiscal year 2026 and $4,890,000 in fiscal year 2027 are from the general fund for the cannabis and substance misuse youth prevention and education program under Minnesota Statutes, section 144.197, subdivision 1.

Subd. 4. **Public Health Infrastructure Funds**

$4,000,000 in fiscal year 2026 and $4,000,000 in fiscal year 2027 are from the general fund to distribute to community health boards and Tribal governments to support their ability to meet national public health standards.

Subd. 5. **Sexual and Reproductive Health Services Grant Program**

$11,483,000 in fiscal year 2026 and $11,483,000 in fiscal year 2027 are from the general fund for the sexual and reproductive health services grant program under Minnesota Statutes, section 145.925.

Subd. 6. **Internal Policy to Promote Diversity, Equity, and Inclusion**

The general fund appropriations in this section include reductions of $337,000 in fiscal year 2026 and $337,000 in fiscal year 2027 for an internal Department of Health policy to promote diversity, equity, and inclusion funded under Laws 2023, chapter 70.

Subd. 7. **Partner Engagement and Staffing**

The general fund appropriations in this section include reductions of $110,000 in fiscal year 2026 and $110,000 in fiscal year 2027 for partner engagement and staffing activities funded under Laws 2023, chapter 70, and Laws 2021, First Special Session chapter 7.

Subd. 8. **Development of Nonopioid Directive Form**

$10,000 in fiscal year 2026 is from the general fund for the development of a nonopioid directive form under Minnesota Statutes, section 145C.18, subdivision 5.

Subd. 9. **Spoken Language Health Care Interpreter Work Group**

$150,000 in fiscal year 2026 is from the general fund for the spoken language health care interpreter work group. This appropriation is available until June 30, 2027.

Subd. 10. **Dementia Services Program**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for the dementia services program under Minnesota Statutes, section 144.063.

Subd. 11. **Opiate Antagonists at Tribal Colleges**

$75,000 in fiscal year 2026 and $75,000 in fiscal year 2027 are from the general fund to make opiate antagonists available at Tribal colleges under Minnesota Statutes, section 135A.1367, subdivision 3.

Subd. 12. **Materials on Recognizing Signs of Physical Abuse in Infants**

$55,000 in fiscal year 2026 is from the general fund for the development of materials on recognizing the signs of physical abuse in infants under Minnesota Statutes, section 144.124, subdivision 2.

Subd. 13. **Opioid Use Prevention and Education**

$500,000 in fiscal year 2026 and $500,000 in fiscal year 2027 are from the general fund for a grant to Change the Outcome to provide:

(1) data-centered learning opportunities on the dangers of opioid use in middle and high schools and communities in Minnesota;

(2) instruction on prevention strategies, assessing personal risk, and how to recognize an overdose;

(3) information on emerging drug trends including but not limited to fentanyl, xylazine, and pressed pills; and

(4) access to resources, including support for those struggling with substance use disorders.

Subd. 14. **Guidelines for Social Media Mental Health Warning Labels**

$45,000 in fiscal year 2026 is from the general fund to develop and review guidelines for social media mental health warning labels under Minnesota Statutes, section 325M.335, subdivision 2.

Subd. 15. **TANF Appropriations**

TANF funds must be used as follows:

(1) $3,579,000 in fiscal year 2026 and $3,579,000 in fiscal year 2027 are from the TANF fund for home visiting and nutritional services listed under Minnesota Statutes, section 145.882,

subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1;

(2) $2,000,000 in fiscal year 2026 and $2,000,000 in fiscal year 2027 are from the TANF fund for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7;

(3) $4,978,000 in fiscal year 2026 and $4,978,000 in fiscal year 2027 are from the TANF fund for the family home visiting grant program under Minnesota Statutes, section 145A.17. Of these amounts, $4,000,000 in fiscal year 2026 and $4,000,000 in fiscal year 2027 must be distributed to community health boards under Minnesota Statutes, section 145A.131, subdivision 1; and $978,000 in fiscal year 2026 and $978,000 in fiscal year 2027 must be distributed to Tribal governments under Minnesota Statutes, section 145A.14, subdivision 2a;

(4) $1,156,000 in fiscal year 2026 and $1,156,000 in fiscal year 2027 are from the TANF fund for sexual and reproductive health services grants under Minnesota Statutes, section 145.925; and

(5) the commissioner may use up to 6.23 percent of the funds appropriated from the TANF fund each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

Subd. 16. **TANF Carryforward**

Any unexpended balance of the TANF appropriation in the first year does not cancel but is available in the second year.

Subd. 17. **Base Level Adjustment**

The general fund base for this section is $207,520,000 in fiscal year 2028 and $207,520,000 in fiscal year 2029.

Sec. 4. **HEALTH PROTECTION**

Subdivision 1. **Total Appropriation**		**$105,523,000**	**$104,982,000**
Appropriations by Fund			
General	34,103,000	33,728,000	
State Government Special Revenue	71,420,000	71,254,000	

Subd. 2. **Infectious Disease Prevention, Early Detection, and Outbreak Response**

$1,300,000 in fiscal year 2026 and $1,300,000 in fiscal year 2027 are from the general fund for infectious disease prevention, early detection, and outbreak response activities under Minnesota Statutes, section 144.05, subdivision 1.

Subd. 3. **Collaborative Funding for State and Outside Partners**

The general fund appropriations in this section include reductions of $30,000 in fiscal year 2026 and $30,000 in fiscal year 2027 for collaborative funding for state and outside partners funded under Laws 2023, chapter 70.

Subd. 4. **Base Level Adjustments**

The general fund base for this section is $33,683,000 in fiscal year 2028 and $33,683,000 in fiscal year 2029. The state government special revenue fund base for this section is $71,265,000 in fiscal year 2028 and $71,277,000 in fiscal year 2029.

Sec. 5. **HEALTH OPERATIONS** **$22,276,000** **$24,749,000**

Appropriations by Fund

General	20,865,000	21,892,000
Health Care Access	1,411,000	2,857,000

Sec. 6. **TRANSFERS.**

Positions, salary money, and nonsalary administrative money may be transferred within the Department of Health as the commissioner deems necessary with the advance approval of the commissioner of management and budget. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health finance quarterly about transfers made under this section.

Sec. 7. **INDIRECT COSTS NOT TO FUND PROGRAMS.**

The commissioner of health shall not use indirect cost allocations to pay for the operational costs of any program for which the commissioner is responsible.

Sec. 8. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 9. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, cancellation, or transfer in this article is enacted more than once during the 2025 regular session, the appropriation, cancellation, or transfer must be given effect once.

Sec. 10. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit or an appropriation is made available after June 30, 2027.

ARTICLE 16
DEPARTMENT OF CHILDREN, YOUTH, AND FAMILIES
APPROPRIATIONS

Section 1. **CHILDREN, YOUTH, AND FAMILIES APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the commissioner of children, youth, and families for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **TOTAL APPROPRIATION**	**$1,312,922,000**	**$1,341,755,000**

Appropriations by Fund

	2026	2027
General	1,084,762,000	1,093,133,000
State Government Special Revenue	732,000	732,000
Federal TANF	227,428,000	247,890,000

The amounts that may be spent for each purpose are specified in the following sections.

Sec. 3. **TANF MAINTENANCE OF EFFORT**

Subdivision 1. **Nonfederal Expenditures**

The commissioner shall ensure that sufficient qualified nonfederal expenditures are made each year to meet the state's maintenance of effort requirements of the TANF block grant specified under Code of Federal Regulations, title 45, section 263.1. In order to meet

these basic TANF maintenance of effort requirements, the commissioner may report as TANF maintenance of effort expenditures only nonfederal money expended for allowable activities listed in the following clauses:

(1) MFIP cash, diversionary work program, and food assistance benefits under Minnesota Statutes, chapter 142G;

(2) the child care assistance programs under Minnesota Statutes, sections 142E.04 and 142E.08, and county child care administrative costs under Minnesota Statutes, section 142E.02, subdivision 9;

(3) state and county MFIP administrative costs under Minnesota Statutes, chapters 142G and 256K;

(4) state, county, and Tribal MFIP employment services under Minnesota Statutes, chapters 142G and 256K;

(5) expenditures made on behalf of legal noncitizen MFIP recipients who qualify for the MinnesotaCare program under Minnesota Statutes, chapter 256L;

(6) qualifying working family credit expenditures under Minnesota Statutes, section 290.0671, and child tax credit expenditures under Minnesota Statutes, section 290.0661;

(7) qualifying Minnesota education credit expenditures under Minnesota Statutes, section 290.0674; and

(8) qualifying Head Start expenditures under Minnesota Statutes, section 142D.12.

Subd. 2. **Nonfederal Expenditures; Reporting**

For the activities listed in subdivision 1, clauses (2) to (8), the commissioner may report only expenditures that are excluded from the definition of assistance under Code of Federal Regulations, title 45, section 260.31.

Subd. 3. **Supplemental Expenditures**

For the purposes of this section, the commissioner may supplement the maintenance of effort claim with working family credit expenditures or other qualified expenditures to the extent such expenditures are otherwise available after considering the expenditures allowed in this section.

Subd. 4. **Reduction of Appropriations; Exception**

The requirement in Minnesota Statutes, section 142A.06, subdivision 3, that federal grants or aids secured or obtained under that subdivision be used to reduce any direct appropriations provided by law does not apply if the grants or aids are federal TANF funds.

Subd. 5. **IT Appropriations Generally**

This appropriation includes funds for information technology projects, services, and support. Funding for information technology project costs must be incorporated into the service level agreement and paid to Minnesota IT Services by the Department of Children, Youth, and Families under the rates and mechanism specified in that agreement.

Subd. 6. **Receipts for Systems Project**

Appropriations and federal receipts for information technology systems projects for MAXIS, PRISM, MMIS, ISDS, METS, and SSIS must be deposited in the state systems account authorized in Minnesota Statutes, section 142A.04. Money appropriated for information technology projects approved by the commissioner of Minnesota IT Services funded by the legislature, and approved by the commissioner of management and budget may be transferred from one project to another and from development to operations as the commissioner of children, youth, and families considers necessary. Any unexpended balance in the appropriation for these projects does not cancel and is available for ongoing development and operations.

Subd. 7. **Federal SNAP Education and Training Grants**

Federal funds available during fiscal years 2026 and 2027 for Supplemental Nutrition Assistance Program Education and Training and SNAP Quality Control Performance Bonus grants are appropriated to the commissioner of human services for the purposes allowable under the terms of the federal award. This subdivision is effective the day following final enactment.

Sec. 4. **CENTRAL OFFICE; AGENCY SUPPORTS**

Subdivision 1. **Total Appropriation** **$138,708,000** **$102,070,000**

Appropriations by Fund

	2026	2027
General	137,876,000	101,238,000
State Government Special Revenue	732,000	732,000
Federal TANF	100,000	100,000

Subd. 2. **Information Technology**

$40,000,000 in fiscal year 2026 is for information technology improvements to SSIS. The appropriation must be used to develop and implement a modernization plan for SSIS that addresses priorities established through collaborative planning with counties and Tribal Nations that use SSIS. Priorities must take into consideration available funding and have a direct impact on child welfare casework. The appropriation must not be used for changes to SSIS that are not part of the child welfare modernization plan. This is a onetime appropriation.

Subd. 3. **Base Level Adjustment**

The general fund base is $95,066,000 in fiscal year 2028 and $95,066,000 in fiscal year 2029.

Sec. 5. **CENTRAL OFFICE; CHILD SAFETY AND PERMANENCY** **$17,232,000** **$16,945,000**

Sec. 6. **CENTRAL OFFICE; EARLY CHILDHOOD** **$17,212,000** **$13,337,000**

Subdivision 1. **Child Care Attendance and Record-Keeping System**

$5,555,000 in fiscal year 2026 and $1,639,000 in fiscal year 2027 are to develop a statewide electronic attendance and record-keeping system for the child care assistance program. The system must provide the commissioner, county agencies, and Tribal Nations that administer the program with real-time access to electronic attendance records to verify children's enrollment in the program. This is a onetime appropriation.

Subd. 2. **Base Level Adjustment**

The general fund base is $11,698,000 in fiscal year 2028 and $11,698,000 in fiscal year 2029.

Sec. 7. **CENTRAL OFFICE; ECONOMIC OPPORTUNITIES AND YOUTH SERVICES** **$3,852,000** **$3,562,000**

Sec. 8. **CENTRAL OFFICE; FAMILY WELL-BEING** **$14,147,000** **$14,147,000**

Appropriations by Fund

	2026	2027
General	10,471,000	10,471,000
Federal TANF	3,676,000	3,676,000

Sec. 9. **FORECASTED PROGRAMS; MFIP/DWP** **$230,473,000** **$268,167,000**

Appropriations by Fund

	2026	2027
General	103,272,000	120,504,000
Federal TANF	127,201,000	147,663,000

Sec. 10. **FORECASTED PROGRAMS; MFIP CHILD CARE ASSISTANCE** **$100,244,000** **$137,333,000**

Sec. 11. **FORECASTED PROGRAMS; NORTHSTAR CARE FOR CHILDREN** **$110,214,000** **$116,160,000**

Sec. 12. **GRANT PROGRAMS; SUPPORT SERVICES GRANTS** **$111,359,000** **$111,359,000**

Appropriations by Fund

	2026	2027
General	14,908,000	14,908,000
Federal TANF	96,451,000	96,451,000

Sec. 13. **GRANT PROGRAMS; BASIC SLIDING FEE CHILD ASSISTANCE CARE GRANTS** **$137,768,000** **$135,212,000**

Sec. 14. **GRANT PROGRAMS; CHILD CARE DEVELOPMENT GRANTS** **$139,319,000** **$138,819,000**

$500,000 in fiscal year 2026 is from the general fund for child care provider access to technology grants under Minnesota Statutes, section 142D.23, subdivision 3, clause (5). This appropriation is available until fiscal year 2029.

Sec. 15. **GRANT PROGRAMS; CHILD SUPPORT ENFORCEMENT GRANTS** **$50,000** **$50,000**

Sec. 16. **GRANT PROGRAMS; CHILDREN'S SERVICES GRANTS** **$43,204,000** **$43,205,000**

The commissioner shall allocate funds from the state's savings from the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for Title IV-E adoption assistance as required in Minnesota Statutes, section 142A.61, and as allowable under federal law. Additional savings to the state as a result of the Fostering Connections to Success and Increasing Adoptions Act's expanded eligibility for Title IV-E adoption assistance is for postadoption, foster care, adoption, and kinship services, including a parent-to-parent support network and as allowable under federal law.

Sec. 17. **GRANT PROGRAMS; CHILDREN AND COMMUNITY SERVICE GRANTS** **$87,984,000** **$87,984,000**

Sec. 18. **GRANT PROGRAMS; CHILDREN AND ECONOMIC SUPPORT GRANTS** **$14,327,000** **$12,426,000**

Subdivision 1. **FAIM**

$209,000 in fiscal year 2026 and $210,000 in fiscal year 2027 are from the general fund for the family assets for independence program. This is a onetime appropriation and is available until fiscal year 2029.

Subd. 2. **American Indian Food Sovereignty Funding Program**

$500,000 in fiscal year 2026 is for the American Indian food sovereignty funding program under Minnesota Statutes, section 142F.15. This is a onetime appropriation and is available until June 30, 2027.

Subd. 3. **Minnesota Food Shelf Program**

$451,000 in fiscal year 2026 is for the Minnesota food shelf program under Minnesota Statutes, section 142F.14. This is a onetime appropriation.

Subd. 4. **Prepared Meals Food Relief**

$451,000 in fiscal year 2026 is for prepared meals food relief grants under Laws 2023, chapter 70, article 12, section 33. This is a onetime appropriation.

Subd. 5. **Minnesota Food Bank Program**

$500,000 in fiscal year 2026 is for Minnesota's regional food banks with an annual operating budget of less than $100,000,000 that the commissioner contracts with for the purposes of the emergency food assistance program (TEFAP). The commissioner shall distribute funding under this paragraph in accordance with the federal TEFAP formula and guidelines of the United States Department of Agriculture. Funding must be used to purchase food that will be distributed free of charge to TEFAP partner agencies. Funding must also cover the handling and delivery fees typically paid by food shelves to food banks to ensure that costs associated with funding under this paragraph are not incurred at the local level. This is a onetime appropriation.

Subd. 6. **Base Level Adjustment**

The general fund base is $12,216,000 in fiscal year 2028 and $12,216,000 in fiscal year 2029.

Sec. 19. **GRANT PROGRAMS; EARLY LEARNING GRANTS** **$138,688,000** **$132,838,000**

Sec. 20. **GRANT PROGRAMS; YOUTH SERVICES GRANTS** **$8,141,000** **$8,141,000**

Subdivision 1. **Restorative Practices Initiative Grant**

$1,750,000 in fiscal year 2026 and $1,750,000 in fiscal year 2027 are from the general fund for restorative practices initiative grants. The general fund base for this appropriation is $2,500,000 in fiscal year 2028 and $2,500,000 in fiscal year 2029.

Subd. 2. **Base Level Adjustment**

The general fund base is $8,891,000 in fiscal year 2028 and $8,891,000 in fiscal year 2029.

Sec. 21. **TECHNICAL ACTIVITIES** **$74,493,000** **$74,493,000**

This appropriation is from the federal TANF fund.

Sec. 22. **APPROPRIATIONS; FOOD ASSISTANCE.**

(a) $2,500,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of children, youth, and families for food shelf programs under Minnesota Statutes, section 142F.14. This is a onetime emergency appropriation with the intent to distribute as quickly as possible and is available until June 30, 2026.

(b) $500,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of children, youth, and families for the American Indian food sovereignty funding program under Minnesota Statutes, section 142F.15. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2026.

(c) $1,000,000 in fiscal year 2025 is appropriated from the general fund to the commissioner of children, youth, and families for contracts with Minnesota's regional food banks with an annual operating budget of less than $100,000,000 for the purposes of The Emergency Food Assistance Program (TEFAP). The commissioner shall distribute the food bank funding under this paragraph in accordance with the federal TEFAP formula and guidelines of the United States Department of Agriculture. Funding must be used by all regional food banks to purchase food that will be distributed free of charge to TEFAP partner agencies. Funding must also cover the handling and delivery fees typically paid by food shelves to food banks to ensure that costs associated with funding under this paragraph are not incurred at the local level. Funding distributed under this paragraph must not be used for food bank administrative costs. This is a onetime appropriation. Notwithstanding Minnesota Statutes, section 16A.28, subdivision 3, this appropriation is available until June 30, 2026.

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

Sec. 23. Laws 2023, chapter 70, article 20, section 8, is amended to read:

Sec. 8. **OFFICE OF THE FOSTER YOUTH OMBUDSPERSON** **$842,000** **$759,000**

This appropriation is available until June 30, 2027.

Sec. 24. **CANCELLATIONS.**

Subdivision 1. **Child welfare initiative grants.** $5,294,000 of the fiscal year 2025 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 22, paragraph (b), is canceled to the general fund.

Subd. 2. **Establishing the Department of Children, Youth, and Families.** $8,500,000 of the fiscal year 2024 general fund appropriation in Laws 2023, chapter 70, article 20, section 12, paragraph (b), is canceled to the general fund.

Subd. 3. **Social service information system technology improvements.** $5,059,000 of the fiscal year 2024 general fund appropriation in Laws 2023, chapter 70, article 20, section 2, subdivision 4, paragraph (g), is canceled to the general fund.

EFFECTIVE DATE. This section is effective the day following final enactment, or retroactively from June 30, 2025, whichever is earlier.

Sec. 25. **TRANSFERS.**

Subdivision 1. **Programs and grants.** The commissioner of children, youth, and families, with the approval of the commissioner of management and budget, may transfer unencumbered appropriation balances for the biennium ending June 30, 2027, within fiscal years among MFIP; MFIP child care assistance under Minnesota Statutes, section 142E.08; the entitlement portion of Northstar Care for Children under Minnesota Statutes, sections 142A.60 to 142A.612; and early childhood family education under Minnesota Statutes, section 142D.11, between fiscal years of the biennium. The commissioner shall inform the chairs and ranking minority members of the legislative committees with jurisdiction over children and families finance and policy quarterly about transfers made under this subdivision.

Subd. 2. **Administration.** Positions, salary money, and nonsalary administrative money may be transferred within the Department of Children, Youth, and Families as the commissioners deem necessary, with the advance approval of the commissioner of management and budget. The commissioners shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over children and families finance quarterly about transfers made under this subdivision.

Subd. 3. **Interdepartmental transfers.** Administrative money may be transferred between the Department of Children, Youth, and Families and Department of Human Services or the Department of Education as the commissioners deem necessary, with the advance approval of the commissioner of management and budget. The commissioners shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over children and families finance and policy quarterly about transfers made under this subdivision.

Sec. 26. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit or an appropriation is made available beyond June 30, 2027.

Sec. 27. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, transfer, or cancellation in this article is enacted more than once during the 2025 regular session, the appropriation, transfer, or cancellation must be given effect once.

ARTICLE 17
OTHER AGENCY HEALTH APPROPRIATIONS

Section 1. **OTHER AGENCY APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	**2027**
Sec. 2. **HEALTH-RELATED BOARDS**		
Subdivision 1. **Total Appropriation**	**$35,241,000**	**$35,127,000**

Appropriations by Fund

	2026	2027
General	643,000	643,000
State Government Special Revenue	34,598,000	34,484,000

These amounts are appropriated from the state government special revenue fund, unless specified otherwise, for the purposes specified in the following subdivisions.

Subd. 2. **Board of Behavioral Health and Therapy**	1,309,000	1,309,000
Subd. 3. **Board of Chiropractic Examiners**	1,114,000	1,114,000
Subd. 4. **Board of Dentistry**	4,308,000	4,310,000

(a) **Administrative services unit; operating costs.** Of this appropriation, $1,936,000 in fiscal year 2026 and $1,936,000 in fiscal year 2027 are for operating costs of the administrative services unit. The administrative services unit may receive and expend reimbursements for services it performs for other agencies.

(b) **Administrative services unit; volunteer health care provider program.** Of this appropriation, $150,000 in fiscal year 2026 and $150,000 in fiscal year 2027 are to pay for medical professional liability coverage required under Minnesota Statutes, section 214.40.

(c) **Administrative services unit; retirement costs.** Of this appropriation, $237,000 in fiscal year 2026 and $237,000 in fiscal year 2027 are for the administrative services unit to pay for the retirement costs of health-related board employees. This funding may be transferred to the health board incurring retirement costs. Any board that has an unexpended balance for an amount transferred under this paragraph shall transfer the unexpended amount to the administrative services unit. If the amount appropriated in the first year of the biennium is not sufficient, the amount from the second year of the biennium is available.

(d) **Administrative services unit; contested cases and other legal proceedings.** Of this appropriation, $200,000 in fiscal year 2026 and $200,000 in fiscal year 2027 are for costs of contested case hearings and other unanticipated costs of legal proceedings involving health-related boards under this section. Upon certification by a health-related board to the administrative services unit that unanticipated costs for legal proceedings will be incurred and that available appropriations are insufficient to pay for the unanticipated costs for that board, the administrative services unit is authorized to transfer money from this appropriation to the board for payment of costs for contested case hearings and other unanticipated costs of legal proceedings with the approval of the commissioner of management and budget. The commissioner of management and budget must require any board that has an unexpended balance or an amount transferred under this paragraph to transfer the unexpended amount to the administrative services unit to be deposited in the state government special revenue fund.

Subd. 5. **Board of Dietetics and Nutrition Practice**	277,000	277,000
Subd. 6. **Board of Executives for Long-term Services and Supports**	835,000	835,000
Subd. 7. **Board of Marriage and Family Therapy**	457,000	457,000
Subd. 8. **Board of Medical Practice**	6,196,000	6,141,000

Base Level Adjustment. The state government special revenue fund base for this subdivision is $6,132,000 in fiscal year 2028 and $6,132,000 in fiscal year 2029.

Subd. 9. **Board of Nursing**	6,275,000	6,275,000
Subd. 10. **Board of Occupational Therapy Practice**	560,000	560,000
Subd. 11. **Board of Optometry**	280,000	280,000
Subd. 12. **Board of Pharmacy**		

	Appropriations by Fund	
General	643,000	643,000
State Government Special Revenue	6,280,000	6,280,000

(a) **Medication Repository Program.** $175,000 in fiscal year 2026 and $175,000 in fiscal year 2027 are from the general fund for the medication repository program under Minnesota Statutes, section 151.555. The general fund base for this appropriation is $450,000 in fiscal year 2028 and $450,000 in fiscal year 2029.

(b) **Base Level Adjustments.** The general fund base for this subdivision is $918,000 in fiscal year 2028 and $918,000 in fiscal year 2029.

Subd. 13. **Board of Physical Therapy**	789,000	789,000
Subd. 14. **Board of Podiatric Medicine**	301,000	301,000
Subd. 15. **Board of Psychology**	2,781,000	2,781,000

Health Professionals Services Program. $1,324,000 in fiscal year 2026 and $1,324,000 in fiscal year 2027 are for the health professionals services program.

Subd. 16. **Board of Social Work**	2,073,000	2,012,000

Base Level Adjustments. The state government special revenue fund base for this subdivision is $2,022,000 in fiscal year 2028 and $2,022,000 in fiscal year 2029.

Subd. 17. **Board of Veterinary Medicine**	763,000	763,000
Sec. 3. **OFFICE OF EMERGENCY MEDICAL SERVICES**	**$22,168,000**	**$20,631,000**

Subdivision 1. **Ambulance Operating Deficit Grant Program**

$9,916,000 in fiscal year 2026 and $9,916,000 in fiscal year 2027 are for the ambulance operating deficit grant program under Minnesota Statutes, section 144E.54. The base for this appropriation is $9,516,000 in fiscal year 2028 and $9,516,000 in fiscal year 2029.

Subd. 2. **Rural EMS Uncompensated Care Pool Payment Program**

$5,239,000 in fiscal year 2026 and $5,267,000 in fiscal year 2027 are for the rural EMS uncompensated care pool payment program under Minnesota Statutes, section 144E.55. The base for this appropriation is $4,978,000 in fiscal year 2028 and $4,978,000 in fiscal year 2029.

Subd. 3. **Base Level Adjustments**

The base for this section is $19,942,000 in fiscal year 2028 and $19,942,000 in fiscal year 2029.

Sec. 4. **RARE DISEASE ADVISORY COUNCIL** **$674,000** **$679,000**

Sec. 5. **BOARD OF DIRECTORS OF MNSURE** **$70,000** **$70,000**

Sec. 6. Laws 2024, chapter 127, article 67, section 4, is amended to read:

Sec. 4. **BOARD OF PHARMACY**

	Appropriations by Fund	
General	1,500,000	-0-
State Government Special Revenue	-0-	27,000

(a) **Legal Costs.** $1,500,000 in fiscal year 2024 is from the general fund for legal costs. This is a onetime appropriation and is available until June 30, 2027.

(b) **Base Level Adjustment.** The state government special revenue fund base is increased by $27,000 in fiscal year 2026 and increased by $27,000 in fiscal year 2027.

EFFECTIVE DATE. This section is effective June 30, 2025.

Sec. 7. **GRANT ADMINISTRATION COSTS.**

The administrative costs retention requirement under Minnesota Statutes, section 16B.98, subdivision 14, is inapplicable to any appropriation in this article for a grant.

Sec. 8. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, cancellation, or transfer in this article is enacted more than once during the 2025 regular session, the appropriation, cancellation, or transfer must be given effect once.

Sec. 9. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires June 30, 2027, unless a different expiration date is explicit or an appropriation is made available after June 30, 2027.

ARTICLE 18
OTHER AGENCY CHILDREN APPROPRIATIONS

Section 1. **OTHER AGENCY APPROPRIATIONS.**

The sums shown in the columns marked "Appropriations" are appropriated to the agencies and for the purposes specified in this article. The appropriations are from the general fund, or another named fund, and are available for the fiscal years indicated for each purpose. The figures "2026" and "2027" used in this article mean that the appropriations listed under them are available for the fiscal year ending June 30, 2026, or June 30, 2027, respectively. "The first year" is fiscal year 2026. "The second year" is fiscal year 2027. "The biennium" is fiscal years 2026 and 2027.

	APPROPRIATIONS Available for the Year Ending June 30	
	2026	2027
Sec. 2. **OMBUDSPERSON FOR FAMILIES**	**$792,000**	**$808,000**
Sec. 3. **OMBUDSPERSON FOR AMERICAN INDIAN FAMILIES**	**$344,000**	**$347,000**
Sec. 4. **OFFICE OF THE FOSTER YOUTH OMBUDSPERSON**	**$772,000**	**$785,000**
Sec. 5. **DEPARTMENT OF EDUCATION**	**$7,950,000**	**$7,950,000**

Sec. 6. **EXPIRATION OF UNCODIFIED LANGUAGE.**

All uncodified language contained in this article expires on June 30, 2027, unless a different expiration date is explicit or an appropriation is made available beyond June 30, 2027.

Sec. 7. **APPROPRIATIONS GIVEN EFFECT ONCE.**

If an appropriation, transfer, or cancellation in this article is enacted more than once during the 2025 regular session, the appropriation, transfer, or cancellation must be given effect once."

Delete the title and insert:

"A bill for an act relating to state government; modifying provisions relating to health finance and policy, certain health licensing boards, pharmacy benefits, health care finance, the Office of Emergency Medical Services, opioids, mental health warning labels, economic assistance, child protection and welfare, early care and learning, and licensing and certification; establishing licensure for certified midwives; requiring reports; providing for civil and criminal penalties; appropriating money; amending Minnesota Statutes 2024, sections 62A.673, subdivision 2; 62J.51, subdivision 19a; 62J.581; 142A.03, subdivision 2, by adding a subdivision; 142A.42; 142B.01, subdivision 15, by adding a subdivision; 142B.05, subdivision 3; 142B.10, subdivisions 14, 16; 142B.16, subdivisions 2, 5; 142B.171, subdivision 2; 142B.18, subdivisions 4, 6; 142B.30, subdivision 1; 142B.41, by adding a subdivision; 142B.47; 142B.51, subdivision 2; 142B.65, subdivisions 8, 9; 142B.66, subdivision 3; 142B.70, subdivisions 7, 8; 142B.77; 142B.80; 142C.06, by adding a subdivision; 142C.11, subdivision 8; 142C.12, subdivisions 1, 6; 142D.21, subdivisions 6, 10, by adding a subdivision; 142D.23, subdivision 3; 142D.31, subdivision 2; 142E.03, subdivision 3; 142E.11, subdivisions 1, 2; 142E.13, subdivision 2; 142E.15, subdivision 1; 142E.16, subdivisions 3, 7; 142E.17, subdivision 9; 142F.14; 144.0758, subdivision 3; 144.1222, subdivision 2d; 144.125, subdivisions 1, 2; 144.50, by adding a subdivision; 144.555, subdivisions 1a, 1b; 144.562, subdivisions 2, 3; 144.563; 144.608, subdivision 2; 144.966, subdivision 2; 144.99, subdivision 1; 145.8811; 145C.01, by adding subdivisions; 145C.17; 147.01, subdivision 7; 147.037, by adding a subdivision; 147D.03, subdivision 1; 148.241; 151.01, subdivision 23; 151.37, subdivision 12; 151.555, subdivisions 6, 10; 152.12, subdivision 1; 174.30, subdivision 3; 245.0962, subdivision 1; 245A.18, subdivision 1; 245C.02, by adding a subdivision; 256.9657, subdivision 2, by adding a subdivision; 256.969, subdivision 2f; 256B.0371, subdivision 3; 256B.04, subdivisions 12, 14; 256B.0625, subdivisions 2, 3b, 13c, 13e, 17, 17a, 30, by adding subdivisions; 256B.064, subdivision 1a; 256B.1973, subdivision 5, by adding a subdivision; 256B.69, subdivisions 3a, 6d; 256R.01, by adding a subdivision; 260.65; 260.66, subdivision 1; 260.691, subdivision 1; 260.692; 260.810, subdivisions 1, 2; 260.821, subdivision 2; 260C.001, subdivision 2; 260C.007, subdivision 19; 260C.141, subdivision 1; 260C.150, subdivision 3; 260C.178, subdivisions 1, 7; 260C.201, subdivisions 1, 2; 260C.202, subdivision 2, by adding subdivisions; 260C.204; 260C.212, subdivisions 1,

1a; 260C.221, subdivision 2; 260C.223, subdivisions 1, 2; 260C.329, subdivisions 3, 8; 260C.451, subdivision 9; 260C.452, subdivision 4; 260E.03, subdivision 15; 260E.09; 260E.20, subdivisions 1, 3; 260E.24, subdivisions 1, 2; 325M.34; 518.68, subdivision 2; 518A.34; 518A.46, subdivision 7; 518A.75, subdivision 1; Laws 2023, chapter 70, article 20, section 8; Laws 2024, chapter 127, article 67, section 4; proposing coding for new law in Minnesota Statutes, chapters 135A; 142B; 144; 144E; 145C; 256B; 260E; 325M; proposing coding for new law as Minnesota Statutes, chapter 148G; repealing Minnesota Statutes 2024, sections 145.361; 256B.0625, subdivisions 18b, 18e, 18h; Laws 2023, chapter 70, article 16, section 22; Minnesota Rules, part 9503.0030, subpart 1, item B."

With the recommendation that when so amended the bill be placed on the General Register.

The report was adopted.

Long and Niska from the Committee on Rules and Legislative Administration to which was referred:

H. F. No. 3228, A bill for an act relating to workers' compensation; adopting recommendations from the Workers' Compensation Advisory Council; amending Minnesota Statutes 2024, sections 176.011, subdivisions 9, 11; 176.041, subdivision 1; 176.135, subdivision 1; 176.151; 176.175, subdivision 2; 176.361, subdivision 2; 176.421, subdivision 4; repealing Minnesota Rules, part 5220.2840.

Reported the same back with the recommendation that the bill be placed on the General Register.

Joint Rule 2.03 has been waived for any subsequent committee action on this bill.

The report was adopted.

SECOND READING OF HOUSE BILLS

H. F. Nos. 2435 and 3228 were read for the second time.

INTRODUCTION AND FIRST READING OF HOUSE BILLS

The following House File was introduced:

Zeleznikar introduced:

H. F. No. 3309, A bill for an act relating to capital investment; appropriating money for water, sewer, and utility improvements in the city of Hermantown; authorizing the sale and issuance of state bonds.

The bill was read for the first time and referred to the Committee on Capital Investment.

Niska moved that the House recess subject to the call of the Chair. The motion prevailed.

RECESS

RECONVENED

The House reconvened and was called to order by the Speaker pro tempore Olson.

REPORT FROM THE COMMITTEE ON RULES
AND LEGISLATIVE ADMINISTRATION

Niska from the Committee on Rules and Legislative Administration, pursuant to rules 1.21 and 3.33, designated the following bills to be placed on the Calendar for the Day for Monday, May 12, 2025 and established a prefiling requirement for amendments offered to the following bills:

H. F. Nos. 2435 and 3228; and S. F. Nos. 908 and 2200.

MESSAGES FROM THE SENATE

The following message was received from the Senate:

Madam Speaker:

I hereby announce the passage by the Senate of the following Senate File, herewith transmitted:

S. F. No. 3446.

THOMAS S. BOTTERN, Secretary of the Senate

FIRST READING OF SENATE BILLS

S. F. No. 3446, A bill for an act relating to claims against the state; providing for the settlement of certain claims; appropriating money.

The bill was read for the first time and referred to the Committee on Ways and Means.

MOTIONS AND RESOLUTIONS

Long moved that the name of Niska be added as an author on H. F. No. 475. The motion prevailed.

Schomacker moved that the name of Gordon be added as an author on H. F. No. 1925. The motion prevailed.

Pursell moved that the name of Norris be added as an author on H. F. No. 3258. The motion prevailed.

Kraft moved that the name of Rehrauer be added as an author on H. F. No. 3302. The motion prevailed.

Hansen, R., moved that the names of Virnig and Jones be added as authors on H. F. No. 3304. The motion prevailed.

Hussein moved that the name of Rehrauer be added as an author on H. F. No. 3306. The motion prevailed.

Sencer-Mura, Finke, Pérez-Vega, Feist and Kozlowski introduced:

House Resolution No. 5, a House resolution condemning presidential executive orders targeting immigrants.

The resolution was referred to the Committee on Rules and Legislative Administration.

ADJOURNMENT

Niska moved that when the House adjourns today it adjourn until 11:00 a.m., Friday, May 9, 2025. The motion prevailed.

Niska moved that the House adjourn. The motion prevailed, and Speaker pro tempore Olson declared the House stands adjourned until 11:00 a.m., Friday, May 9, 2025.

PATRICK DUFFY MURPHY, Chief Clerk, House of Representatives