

1.1 ..... moves to amend H.F. No. 2115 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "ARTICLE 1

1.4 AGING AND DISABILITY SERVICES

1.5 Section 1. Minnesota Statutes 2024, section 245D.091, subdivision 3, is amended to read:

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

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

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

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

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

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

- 2.1 (2) have received training prior to hire or within 90 calendar days of hire that includes:
- 2.2 (i) ten hours of instruction in functional assessment and functional analysis;
- 2.3 (ii) 20 hours of instruction in the understanding of the function of behavior;
- 2.4 (iii) ten hours of instruction on design of positive practices behavior support strategies;
- 2.5 (iv) 20 hours of instruction preparing written intervention strategies, designing data
- 2.6 collection protocols, training other staff to implement positive practice strategies,
- 2.7 summarizing and reporting program evaluation data, analyzing program evaluation data to
- 2.8 identify design flaws in behavioral interventions or failures in implementation fidelity, and
- 2.9 recommending enhancements based on evaluation data; and
- 2.10 (v) eight hours of instruction on principles of person-centered thinking;
- 2.11 (3) be determined by a positive support professional to have the training and prerequisite
- 2.12 skills required to provide positive practice strategies as well as behavior reduction approved
- 2.13 and permitted intervention to the person who receives positive support; and
- 2.14 (4) be under the direct supervision of a positive support professional.
- 2.15 (c) Meeting the qualifications for a positive support professional under subdivision 2
- 2.16 shall substitute for meeting the qualifications listed in paragraph (b).
- 2.17 Sec. 2. Minnesota Statutes 2024, section 252.43, is amended to read:
- 2.18 **252.43 COMMISSIONER'S DUTIES.**
- 2.19 (a) The commissioner shall supervise lead agencies' provision of day services to adults
- 2.20 with disabilities. The commissioner shall:
- 2.21 (1) determine the need for day programs, except for adult day services, under sections
- 2.22 256B.4914 and 252.41 to 252.46 operated in a day services facility licensed under sections
- 2.23 245D.27 to 245D.31;
- 2.24 (2) establish payment rates as provided under section 256B.4914;
- 2.25 (3) adopt rules for the administration and provision of day services under sections
- 2.26 245A.01 to 245A.16; 252.28, subdivision 2; or 252.41 to 252.46; or Minnesota Rules, parts
- 2.27 9525.1200 to 9525.1330;
- 2.28 (4) enter into interagency agreements necessary to ensure effective coordination and
- 2.29 provision of day services;
- 2.30 (5) monitor and evaluate the costs and effectiveness of day services; and

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

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

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

3.6 Sec. 3. Minnesota Statutes 2024, section 252.46, subdivision 1a, is amended to read:

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

3.13 (b) The commissioner shall consult with stakeholders prior to modifying rates under  
3.14 this subdivision.

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

3.16 Sec. 4. **[256B.0909] LONG-TERM CARE DECISION REVIEWS.**

3.17 Subdivision 1. **Opportunity to respond required.** The lead agency shall initiate a  
3.18 decision review if requested by a person or a person's legal representative within ten calendar  
3.19 days of receiving an agency notice to deny, reduce, suspend, or terminate the person's access  
3.20 to or eligibility for the following programs:

3.21 (1) home and community-based waivers, including level of care determinations, under  
3.22 sections 256B.092 and 256B.49;

3.23 (2) specific home and community-based services available under sections 256B.092 and  
3.24 256B.49;

3.25 (3) consumer-directed community supports;

3.26 (4) the following state plan services:

3.27 (i) personal care assistance services under section 256B.0625, subdivisions 19a and 19c;

3.28 (ii) consumer support grants under section 256.476; or

3.29 (iii) community first services and supports under section 256B.85;

3.30 (5) semi-independent living services under section 252.275;

4.1 (6) relocation targeted case management services available under section 256B.0621,  
4.2 subdivision 2, clause (4);

4.3 (7) case management services targeted to vulnerable adults or people with developmental  
4.4 disabilities under section 256B.0924;

4.5 (8) case management services targeted to people with developmental disabilities under  
4.6 Minnesota Rules, part 9525.0016; and

4.7 (9) necessary diagnostic information to gain access to or determine eligibility under  
4.8 clauses (5) to (8).

4.9 Subd. 2. **Decision review.** (a) A lead agency must schedule a decision review for any  
4.10 person who responds under subdivision 1 within ten calendar days of the request for review.

4.11 (b) The lead agency must conduct the decision review in a manner that allows an  
4.12 opportunity for interactive communication between the person and a representative of the  
4.13 lead agency who has specific knowledge of the proposed decision and the basis for the  
4.14 decision. The interactive communication must be in a format that is accessible to the recipient,  
4.15 and may include a phone call, a written exchange, an in-person meeting, or another format  
4.16 as chosen by the person or the person's legal representative, if any.

4.17 (c) During the decision review, the representative of the lead agency must provide a  
4.18 thorough explanation of the lead agency's intent to deny, reduce, suspend, or terminate  
4.19 eligibility or access to the services described in subdivision 1 and provide the person or the  
4.20 person's legal representative, if any, an opportunity to ask questions about the decision. If  
4.21 the lead agency's explanation of the decision is based on a misunderstanding of the person's  
4.22 circumstances, incomplete information, missing documentation, or similar missing or  
4.23 inaccurate information, the lead agency must provide the person or the person's legal  
4.24 representative, if any, an opportunity to provide clarifying or additional information.

4.25 (d) A person with a legal representative is not required to participate in the decision  
4.26 review. A person may also have someone of the person's choosing participate in the decision  
4.27 review.

4.28 Subd. 3. **Appeals.** If the lead agency ignores the request for review or does not schedule  
4.29 the review in at least ten calendar days prior to the hearing, the judge shall reschedule the  
4.30 hearing to allow for at least ten calendar days between the review and the hearing.

5.1 Sec. 5. Minnesota Statutes 2024, section 256B.092, subdivision 1a, is amended to read:

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

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

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

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

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

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

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

5.14 (ii) employment service providers;

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

5.16 (iv) providers of financial management services;

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

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

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

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

5.23 (c) Case management service activities that are provided to the person with a  
5.24 developmental disability shall be provided directly by county agencies or under contract.  
5.25 If a county agency contracts for case management services, the county agency must provide  
5.26 each recipient of home and community-based services who is receiving contracted case  
5.27 management services with the contact information the recipient may use to file a grievance  
5.28 with the county agency about the quality of the contracted services the recipient is receiving  
5.29 from a county-contracted case manager. If a county agency provides case management  
5.30 under contracts with other individuals or agencies and the county agency utilizes a  
5.31 competitive proposal process for the procurement of contracted case management services,

6.1 the competitive proposal process must include evaluation criteria to ensure that the county  
6.2 maintains a culturally responsive program for case management services adequate to meet  
6.3 the needs of the population of the county. For the purposes of this section, "culturally  
6.4 responsive program" means a case management services program that: (1) ensures effective,  
6.5 equitable, comprehensive, and respectful quality care services that are responsive to  
6.6 individuals within a specific population's values, beliefs, practices, health literacy, preferred  
6.7 language, and other communication needs; and (2) is designed to address the unique needs  
6.8 of individuals who share a common language or racial, ethnic, or social background.

6.9 (d) Case management services must be provided by a public or private agency that is  
6.10 enrolled as a medical assistance provider determined by the commissioner to meet all of  
6.11 the requirements in the approved federal waiver plans. Case management services must not  
6.12 be provided to a recipient by a private agency that has a financial interest in the provision  
6.13 of any other services included in the recipient's support plan. For purposes of this section,  
6.14 "private agency" means any agency that is not identified as a lead agency under section  
6.15 256B.0911, subdivision 10.

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

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

6.27 (1) phasing out the use of prohibited procedures;

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

6.30 (3) accomplishment of identified outcomes.

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

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

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

7.16 Sec. 6. Minnesota Statutes 2024, section 256B.092, subdivision 11a, is amended to read:

7.17 Subd. 11a. **Residential support services criteria.** (a) For the purposes of this subdivision,  
7.18 "residential support services" means the following residential support services reimbursed  
7.19 under section 256B.4914: community residential services, customized living services, and  
7.20 24-hour customized living services.

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

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

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

7.31 (c) Nothing in this subdivision shall be construed as permitting the commissioner to  
7.32 establish criteria prohibiting the authorization of residential support services for individuals  
7.33 described in the statewide priorities established in subdivision 12, the transition populations

8.1 in subdivision 13, and the licensing moratorium exception criteria under section 245A.03,  
8.2 subdivision 7, paragraph (a).

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

8.7 **EFFECTIVE DATE.** This section is effective 90 days following federal approval of  
8.8 Laws 2021, First Special Session chapter 7, article 13, section 18.

8.9 Sec. 7. Minnesota Statutes 2024, section 256B.49, subdivision 13, is amended to read:

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

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

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

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

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

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

8.21 (iii) employment service providers;

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

8.23 and

8.24 (v) providers of financial management services;

8.25 (4) assisting the recipient to access services and assisting with appeals under section  
8.26 256.045; and

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

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

9.1 (1) finalizing the person-centered support plan;

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

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

9.5 (c) Case management services must be provided by a public or private agency that is  
9.6 enrolled as a medical assistance provider determined by the commissioner to meet all of  
9.7 the requirements in the approved federal waiver plans. If a county agency provides case  
9.8 management under contracts with other individuals or agencies and the county agency  
9.9 utilizes a competitive proposal process for the procurement of contracted case management  
9.10 services, the competitive proposal process must include evaluation criteria to ensure that  
9.11 the county maintains a culturally responsive program for case management services adequate  
9.12 to meet the needs of the population of the county. For the purposes of this section, "culturally  
9.13 responsive program" means a case management services program that: (1) ensures effective,  
9.14 equitable, comprehensive, and respectful quality care services that are responsive to  
9.15 individuals within a specific population's values, beliefs, practices, health literacy, preferred  
9.16 language, and other communication needs; and (2) is designed to address the unique needs  
9.17 of individuals who share a common language or racial, ethnic, or social background.

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

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

9.29 (1) phasing out the use of prohibited procedures;

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

9.32 (3) accomplishment of identified outcomes.

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

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

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

10.19 Sec. 8. Minnesota Statutes 2024, section 256B.49, subdivision 29, is amended to read:

10.20 Subd. 29. **Residential support services criteria.** (a) For the purposes of this subdivision,  
10.21 "residential support services" means the following residential support services reimbursed  
10.22 under section 256B.4914: community residential services, customized living services, and  
10.23 24-hour customized living services.

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

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

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

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

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

11.10 **EFFECTIVE DATE.** This section is effective 90 days following federal approval of  
11.11 Laws 2021, First Special Session chapter 7, article 13, section 30.

11.12 Sec. 9. Minnesota Statutes 2024, section 256B.4911, subdivision 6, is amended to read:

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

11.18 (1) alternative care program;

11.19 (2) brain injury waiver;

11.20 (3) community alternative care waiver;

11.21 (4) community access for disability inclusion waiver;

11.22 (5) developmental disabilities waiver; and

11.23 (6) elderly waiver.

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

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

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

12.4 (e) A parent may provide personal assistance services to a minor child who has an  
12.5 assessed activity of daily living dependency requiring supervision, direction, cueing, or  
12.6 hands-on assistance, including when provided while traveling temporarily out-of-state.

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

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

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

12.14 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure  
12.15 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the  
12.16 service. As determined by the commissioner, in consultation with stakeholders identified  
12.17 in subdivision 17, a provider enrolled to provide services with rates determined under this  
12.18 section must submit requested cost data to the commissioner to support research on the cost  
12.19 of providing services that have rates determined by the disability waiver rates system.

12.20 Requested cost data may include, but is not limited to:

12.21 (1) worker wage costs;

12.22 (2) benefits paid;

12.23 (3) supervisor wage costs;

12.24 (4) executive wage costs;

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

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

12.27 (7) administrative costs paid;

12.28 (8) program costs paid;

12.29 (9) transportation costs paid;

12.30 (10) vacancy rates; and

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

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

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

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

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

13.23 **EFFECTIVE DATE.** This section is effective retroactive to January 1, 2025.

13.24 Sec. 11. Minnesota Statutes 2024, section 256B.4914, subdivision 10d, is amended to  
13.25 read:

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

13.29 (b) A provider paid with rates determined under subdivision 7 must use a minimum of  
13.30 45 percent of the revenue generated by rates determined under that subdivision for direct  
13.31 care staff compensation.

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

14.4 (d) Compensation under this subdivision includes:

14.5 (1) wages;

14.6 (2) taxes and workers' compensation;

14.7 (3) health insurance;

14.8 (4) dental insurance;

14.9 (5) vision insurance;

14.10 (6) life insurance;

14.11 (7) short-term disability insurance;

14.12 (8) long-term disability insurance;

14.13 (9) retirement spending;

14.14 (10) tuition reimbursement;

14.15 (11) wellness programs;

14.16 (12) paid vacation time;

14.17 (13) paid sick time; or

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

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

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

14.23 **EFFECTIVE DATE.** This section is effective retroactive to January 1, 2025.

14.24 Sec. 12. Minnesota Statutes 2024, section 256R.38, is amended to read:

14.25 **256R.38 PERFORMANCE-BASED INCENTIVE PAYMENTS.**

14.26 The commissioner shall develop additional incentive-based payments of up to five  
14.27 percent above a facility's operating payment rate for achieving outcomes specified in a  
14.28 contract. The commissioner may solicit proposals and select those which, on a competitive  
14.29 basis, best meet the state's policy objectives. The commissioner shall limit the amount of

15.1 any incentive payment and the number of contract amendments under this section to operate  
15.2 the incentive payments within funds appropriated for this purpose. The commissioner shall  
15.3 approve proposals through a memorandum of understanding which shall specify various  
15.4 levels of payment for various levels of performance. Incentive payments to facilities under  
15.5 this section shall be in the form of time-limited rate adjustments which shall be included in  
15.6 the external fixed costs payment rate under section 256R.25. In establishing the specified  
15.7 outcomes and related criteria, the commissioner shall consider the following state policy  
15.8 objectives:

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

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

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

15.13 (4) reduced acute care costs; and

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

15.16 Sec. 13. Minnesota Statutes 2024, section 256R.40, subdivision 5, is amended to read:

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

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

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

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

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

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

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

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

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

16.11 **Sec. 14. DIRECTION TO COMMISSIONER; NOTICE OF ACTION REVISION.**

16.12 By July 1, 2025, the commissioner of human services shall review and make changes  
16.13 to the Notice of Action form to incorporate the long-term care decision review process in  
16.14 Minnesota Statutes, section 256B.0909.

16.15 **ARTICLE 2**

16.16 **DEPARTMENT OF HEALTH POLICY**

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

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

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

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

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

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

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

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

17.7 (g) "Patient Driven Payment Model" or "PDPM" means a case mix classification system  
17.8 for residents in nursing facilities based on the resident's condition, diagnosis, and the care  
17.9 the resident is receiving based on data supplied in the facility's MDS for assessments with  
17.10 an ARD on or after October 1, 2025.

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

17.15 (1) nursing facility services under chapter 256R;

17.16 (2) elderly waiver services under chapter 256S;

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

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

17.19 (i) "Resource utilization groups" or "RUG" means a system for grouping a nursing  
17.20 facility's residents according to the resident's clinical and functional status identified in data  
17.21 supplied by the facility's minimum data set with an ARD on or prior to September 30, 2025.

17.22 Sec. 2. Minnesota Statutes 2024, section 144.0724, subdivision 3a, is amended to read:

17.23 Subd. 3a. **Resident case mix reimbursement classifications.** (a) Resident case mix  
17.24 reimbursement classifications shall be based on the Minimum Data Set, version 3.0  
17.25 assessment instrument, or its successor version mandated by the Centers for Medicare and  
17.26 Medicaid Services that nursing facilities are required to complete for all residents. Case  
17.27 mix reimbursement classifications shall also be based on assessments required under  
17.28 subdivision 4. Assessments must be completed according to the Long Term Care Facility  
17.29 Resident Assessment Instrument User's Manual Version 3.0 or a successor manual issued  
17.30 by the Centers for Medicare and Medicaid Services. On or before September 30, 2025, the  
17.31 optional state assessment must be completed according to the OSA Manual Version 1.0 v.2.

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

18.4 Sec. 3. Minnesota Statutes 2024, section 144.0724, subdivision 4, is amended to read:

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

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

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

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

18.20 (3) a significant change in status comprehensive assessment, which must have an ARD  
18.21 within 14 days after the facility determines, or should have determined, that there has been  
18.22 a significant change in the resident's physical or mental condition, whether an improvement  
18.23 or a decline, and regardless of the amount of time since the last comprehensive assessment  
18.24 or quarterly review assessment. Effective October 1, 2025, a significant change in status  
18.25 assessment is also required when isolation for an infectious disease has ended. If isolation  
18.26 was not coded on the most recent OBRA assessment completed, then the significant change  
18.27 in status assessment is not required. The ARD of this assessment must be set on day 15 after  
18.28 isolation has ended;

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

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

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

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

19.4 (c) On or before September 30, 2025, the optional state assessment must accompany all  
19.5 OBRA assessments. The optional state assessment is also required to determine  
19.6 reimbursement when:

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

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

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

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

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

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

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

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

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

20.1 (d) The commissioner shall consider documentation under the time frames for coding  
20.2 items on the minimum data set as set out in the Long-Term Care Facility Resident Assessment  
20.3 Instrument User's Manual or on or before September 30, 2025, the OSA Manual version  
20.4 1.0 v.2 published by the Centers for Medicare and Medicaid Services.

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

20.7 (1) Each facility shall be audited annually. If a facility has two successive audits in which  
20.8 the percentage of change is five percent or less and the facility has not been the subject of  
20.9 a special audit in the past 36 months, the facility may be audited biannually. A stratified  
20.10 sample of 15 percent, with a minimum of ten assessments, of the most current assessments  
20.11 shall be selected for audit. If more than 20 percent of the case mix reimbursement  
20.12 classifications are changed as a result of the audit, the audit shall be expanded to a second  
20.13 15 percent sample, with a minimum of ten assessments. If the total change between the first  
20.14 and second samples is 35 percent or greater, the commissioner may expand the audit to all  
20.15 of the remaining assessments.

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

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

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

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

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

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

20.28 (v) a criminal indictment alleging provider fraud;

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

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

20.31 (viii) nonsubmission of assessments;

20.32 (ix) late submission of assessments; or

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

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

21.12 Sec. 5. Minnesota Statutes 2024, section 144.651, subdivision 10a, is amended to read:

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

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

21.25 (c) A facility may restrict or prohibit the presence of a designated support person in  
21.26 treatment rooms, procedure rooms, and operating rooms when such a restriction or prohibition  
21.27 is strictly necessary to meet the appropriate standard of care. A facility may also restrict or  
21.28 prohibit the presence of a designated support person if the designated support person is  
21.29 acting in a violent or threatening manner toward others. Any restriction or prohibition of a  
21.30 designated support person by the facility is subject to the facility's written internal grievance  
21.31 procedure required by subdivision 20.

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

22.1 Sec. 6. Minnesota Statutes 2024, section 144A.61, is amended by adding a subdivision to  
22.2 read:

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

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

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

22.16 Sec. 8. Minnesota Statutes 2024, section 144A.70, subdivision 3, is amended to read:

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

22.24 Sec. 9. Minnesota Statutes 2024, section 144A.70, is amended by adding a subdivision to  
22.25 read:

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

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

23.3 Subd. 3b. **Indirect ownership interest.** "Indirect ownership interest" means an individual  
23.4 or legal entity with a direct ownership interest in an entity that has a direct or indirect  
23.5 ownership interest of at least five percent in an entity that is a registrant.

23.6 Sec. 11. Minnesota Statutes 2024, section 144A.70, subdivision 7, is amended to read:

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

23.11 Sec. 12. Minnesota Statutes 2024, section 144G.10, subdivision 1, is amended to read:

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

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

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

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

23.29 (d) Upon approving an application for an assisted living facility license, the commissioner  
23.30 may issue a single license for two or more buildings on a campus that are operated by the  
23.31 same licensee as an assisted living facility. An assisted living facility license for a campus

24.1 must identify the address and licensed resident capacity of each building located on the  
24.2 campus in which assisted living services are provided.

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

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

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

24.11 Sec. 13. Minnesota Statutes 2024, section 144G.10, subdivision 1a, is amended to read:

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

24.15 Sec. 14. Minnesota Statutes 2024, section 144G.10, subdivision 5, is amended to read:

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

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

24.26 Sec. 15. Minnesota Statutes 2024, section 144G.16, subdivision 3, is amended to read:

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

24.30 (b) If the provisional licensee is not in substantial compliance with the initial survey,  
24.31 the commissioner shall either: (1) not issue the facility license and terminate the provisional

25.1 license; or (2) extend the provisional license for a period not to exceed 90 calendar days  
25.2 and apply conditions necessary to bring the facility into substantial compliance. If the  
25.3 provisional licensee is not in substantial compliance with the survey within the time period  
25.4 of the extension or if the provisional licensee does not satisfy the license conditions, the  
25.5 commissioner may deny the license.

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

25.9 Sec. 16. Minnesota Statutes 2024, section 144G.19, is amended by adding a subdivision  
25.10 to read:

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

25.14 **EFFECTIVE DATE.** This section is effective January 1, 2026, and applies to all assisted  
25.15 living contracts executed after a change of ownership that occurs on or after that date.

25.16 Sec. 17. Minnesota Statutes 2024, section 144G.52, is amended by adding a subdivision  
25.17 to read:

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

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

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

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

26.7 Sec. 18. Minnesota Statutes 2024, section 144G.53, is amended to read:

26.8 **144G.53 NONRENEWAL OF HOUSING.**

26.9 Subdivision 1. Notice or termination procedure. (a) If a facility decides to not renew  
26.10 a resident's housing under a contract, the facility must either (1) provide the resident with  
26.11 60 calendar days' notice of the nonrenewal and assistance with relocation planning, or (2)  
26.12 follow the termination procedure under section 144G.52.

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

26.16 (c) A facility must:

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

26.19 (2) for residents who receive home and community-based waiver services under chapter  
26.20 256S and section 256B.49, provide notice to the resident's case manager;

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

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

27.1 and of the resident's obligation to notify the facility of the resident's intent to apply for public  
 27.2 assistance and to make a timely application for public assistance.

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

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

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

27.11 ~~(3)~~ (1) ensure a coordinated move to a safe location, as defined in section 144G.55,  
 27.12 subdivision 2, that is appropriate for the resident;

27.13 ~~(4)~~ (2) ensure a coordinated move to an appropriate service provider identified by the  
 27.14 facility, if services are still needed and desired by the resident;

27.15 ~~(5)~~ (3) consult and cooperate with the resident, legal representative, designated  
 27.16 representative, case manager for a resident who receives home and community-based waiver  
 27.17 services under chapter 256S and section 256B.49, relevant health professionals, and any  
 27.18 other persons of the resident's choosing to make arrangements to move the resident, including  
 27.19 consideration of the resident's goals; and

27.20 ~~(6)~~ (4) prepare a written plan to prepare for the move.

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

27.26 Sec. 19. Minnesota Statutes 2024, section 144G.81, subdivision 1, is amended to read:

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

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

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

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

28.5 Sec. 20. Minnesota Statutes 2024, section 144G.91, is amended by adding a subdivision  
28.6 to read:

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

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

28.14 (c) A facility may restrict or prohibit the presence of a designated support person if the  
28.15 designated support person is acting in a violent or threatening manner toward others. If the  
28.16 facility restricts or prohibits a resident's designated support person from being present, the  
28.17 resident may file a complaint or inquiry with the facility according to subdivision 20, the  
28.18 Office of Ombudsman for Long-Term Care, or the Office of Ombudsman for Mental Health  
28.19 and Developmental Disabilities.

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

28.21 Sec. 21. Minnesota Statutes 2024, section 148.235, subdivision 10, is amended to read:

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

29.1 Sec. 22. **REVISOR INSTRUCTION.**

29.2 The revisor of statutes must modify the section headnote for Minnesota Statutes, section  
 29.3 144G.81, to read "ADDITIONAL REQUIREMENTS FOR ASSISTED LIVING  
 29.4 FACILITIES WITH DEMENTIA CARE AND ASSISTED LIVING FACILITIES WITH  
 29.5 SECURED DEMENTIA CARE UNITS."

29.6 Sec. 23. **REPEALER.**

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

29.8 **ARTICLE 3**29.9 **DIRECT CARE AND TREATMENT**

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

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

29.17 (1) pursuant to section 13.05;

29.18 (2) pursuant to statute or valid court order;

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

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

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

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

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

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

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

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

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

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

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

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

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

30.32 (ii) Except as provided in item (v), when a correction order, an order to forfeit a fine,  
30.33 an order of license suspension, an order of temporary immediate suspension, an order of

31.1 license revocation, an order of license denial, or an order of conditional license has been  
31.2 issued, or a complaint is resolved, the following data on current and former licensees and  
31.3 applicants are public: the general nature of the complaint or allegations leading to the  
31.4 temporary immediate suspension; the substance and investigative findings of the licensing  
31.5 or maltreatment complaint, licensing violation, or substantiated maltreatment; the existence  
31.6 of settlement negotiations; the record of informal resolution of a licensing violation; orders  
31.7 of hearing; findings of fact; conclusions of law; specifications of the final correction order,  
31.8 fine, suspension, temporary immediate suspension, revocation, denial, or conditional license  
31.9 contained in the record of licensing action; whether a fine has been paid; and the status of  
31.10 any appeal of these actions.

31.11 (iii) When a license denial under section 142A.15 or 245A.05 or a sanction under section  
31.12 142B.18 or 245A.07 is based on a determination that a license holder, applicant, or controlling  
31.13 individual is responsible for maltreatment under section 626.557 or chapter 260E, the identity  
31.14 of the applicant, license holder, or controlling individual as the individual responsible for  
31.15 maltreatment is public data at the time of the issuance of the license denial or sanction.

31.16 (iv) When a license denial under section 142A.15 or 245A.05 or a sanction under section  
31.17 142B.18 or 245A.07 is based on a determination that a license holder, applicant, or controlling  
31.18 individual is disqualified under chapter 245C, the identity of the license holder, applicant,  
31.19 or controlling individual as the disqualified individual is public data at the time of the  
31.20 issuance of the licensing sanction or denial. If the applicant, license holder, or controlling  
31.21 individual requests reconsideration of the disqualification and the disqualification is affirmed,  
31.22 the reason for the disqualification and the reason to not set aside the disqualification are  
31.23 private data.

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

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

31.32 (3) For applicants who are denied a license, the following data are public: the name and  
31.33 address of the applicant, the city and county in which the applicant was seeking licensure,  
31.34 the dates of the commissioner's receipt of the initial application and completed application,

32.1 the type of license sought, the date of denial of the application, the nature of the basis for  
32.2 the denial, the existence of settlement negotiations, the record of informal resolution of a  
32.3 denial, orders of hearings, findings of fact, conclusions of law, specifications of the final  
32.4 order of denial, and the status of any appeal of the denial.

32.5 (4) When maltreatment is substantiated under section 626.557 or chapter 260E and the  
32.6 victim and the substantiated perpetrator are affiliated with a program licensed under chapter  
32.7 142B or 245A; the commissioner of human services; commissioner of children, youth, and  
32.8 families; local social services agency; or county welfare agency may inform the license  
32.9 holder where the maltreatment occurred of the identity of the substantiated perpetrator and  
32.10 the victim.

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

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

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

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

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

33.1 (g) Data that are not public data collected, maintained, used, or disseminated under this  
33.2 subdivision that relate to or are derived from a report as defined in section 260E.03, or  
33.3 626.5572, subdivision 18, are subject to the destruction provisions of sections 260E.35,  
33.4 subdivision 6, and 626.557, subdivision 12b.

33.5 (h) Upon request, not public data collected, maintained, used, or disseminated under  
33.6 this subdivision that relate to or are derived from a report of substantiated maltreatment as  
33.7 defined in section 626.557 or chapter 260E may be exchanged with the Department of  
33.8 Health for purposes of completing background studies pursuant to section 144.057 and with  
33.9 the Department of Corrections for purposes of completing background studies pursuant to  
33.10 section 241.021.

33.11 (i) Data on individuals collected according to licensing activities under chapters 142B,  
33.12 245A, and 245C, data on individuals collected by the commissioner of human services  
33.13 according to investigations under section 626.557 and chapters 142B, 245A, 245B, 245C,  
33.14 245D, and 260E may be shared with the Department of Human Rights, the Department of  
33.15 Health, the Department of Corrections, the ombudsman for mental health and developmental  
33.16 disabilities, and the individual's professional regulatory board when there is reason to believe  
33.17 that laws or standards under the jurisdiction of those agencies may have been violated or  
33.18 the information may otherwise be relevant to the board's regulatory jurisdiction. Background  
33.19 study data on an individual who is the subject of a background study under chapter 245C  
33.20 for a licensed service for which the commissioner of human services ~~or~~ commissioner of  
33.21 children, youth, and families; or the Direct Care and Treatment executive board is the license  
33.22 holder may be shared with the commissioner and the commissioner's delegate by the licensing  
33.23 division. Unless otherwise specified in this chapter, the identity of a reporter of alleged  
33.24 maltreatment or licensing violations may not be disclosed.

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

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

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

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

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

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

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

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

34.20 (c) "Party" does not include a person providing services pursuant to licensure or  
34.21 reimbursement on a cost basis by the Department of Health or the Department of Human  
34.22 Services, or Direct Care and Treatment when that person is named or admitted or seeking  
34.23 to be admitted as a party in a matter which involves the licensing or reimbursement rates,  
34.24 procedures, or methodology applicable to those services.

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

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

34.27 **43A.241 INSURANCE CONTRIBUTIONS; FORMER EMPLOYEES.**

34.28 (a) This section applies to a person who:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

36.17 (c) This subdivision expires June 30, 2031.

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

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

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

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

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

36.26 **144.53 FEES.**

36.27 Each application for a license, or renewal thereof, to operate a hospital, sanitarium or  
36.28 other institution for the hospitalization or care of human beings, within the meaning of  
36.29 sections 144.50 to 144.56, except applications by the Minnesota Veterans Home, the  
36.30 ~~commissioner of human services~~ Direct Care and Treatment executive board for the licensing  
36.31 of state institutions, ~~or by the administrator for the licensing of the University of Minnesota~~  
36.32 hospitals, shall be accompanied by a fee to be prescribed by the state commissioner of health

37.1 pursuant to section 144.122. No fee shall be refunded. Licenses shall expire and shall be  
37.2 renewed as prescribed by the commissioner of health pursuant to section 144.122.

37.3 No license granted hereunder shall be assignable or transferable.

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

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

37.6 Subd. 2. **Definitions.** (a) For the purposes of this section, "patient" means a person who  
37.7 is admitted to an acute care inpatient facility for a continuous period longer than 24 hours,  
37.8 for the purpose of diagnosis or treatment bearing on the physical or mental health of that  
37.9 person. For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also  
37.10 means a person who receives health care services at an outpatient surgical center or at a  
37.11 birth center licensed under section 144.615. "Patient" also means a minor who is admitted  
37.12 to a residential program as defined in ~~section 253C.01~~ paragraph (c). For purposes of  
37.13 subdivisions 1, 3 to 16, 18, 20 and 30, "patient" also means any person who is receiving  
37.14 mental health treatment on an outpatient basis or in a community support program or other  
37.15 community-based program.

37.16 (b) "Resident" means a person who is admitted to a nonacute care facility including  
37.17 extended care facilities, nursing homes, and boarding care homes for care required because  
37.18 of prolonged mental or physical illness or disability, recovery from injury or disease, or  
37.19 advancing age. For purposes of all subdivisions except subdivisions 28 and 29, "resident"  
37.20 also means a person who is admitted to a facility licensed as a board and lodging facility  
37.21 under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care home under sections  
37.22 144.50 to 144.56, or a supervised living facility under Minnesota Rules, parts 4665.0100  
37.23 to 4665.9900, and which operates a rehabilitation program licensed under chapter 245G or  
37.24 245I, or Minnesota Rules, parts 9530.6510 to 9530.6590.

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

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

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

38.2 Subd. 4. **Information about rights.** Patients and residents shall, at admission, be told  
38.3 that there are legal rights for their protection during their stay at the facility or throughout  
38.4 their course of treatment and maintenance in the community and that these are described  
38.5 in an accompanying written statement of the applicable rights and responsibilities set forth  
38.6 in this section. In the case of patients admitted to residential programs ~~as defined in section~~  
38.7 ~~253C.01~~, the written statement shall also describe the right of a person 16 years old or older  
38.8 to request release as provided in section 253B.04, subdivision 2, and shall list the names  
38.9 and telephone numbers of individuals and organizations that provide advocacy and legal  
38.10 services for patients in residential programs. Reasonable accommodations shall be made  
38.11 for people who have communication disabilities and those who speak a language other than  
38.12 English. Current facility policies, inspection findings of state and local health authorities,  
38.13 and further explanation of the written statement of rights shall be available to patients,  
38.14 residents, their guardians or their chosen representatives upon reasonable request to the  
38.15 administrator or other designated staff person, consistent with chapter 13, the Data Practices  
38.16 Act, and section 626.557, relating to vulnerable adults.

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

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

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

38.28 Every acute care inpatient facility, every residential program ~~as defined in section~~  
38.29 ~~253C.01~~, every nonacute care facility, and every facility employing more than two people  
38.30 that provides outpatient mental health services shall have a written internal grievance  
38.31 procedure that, at a minimum, sets forth the process to be followed; specifies time limits,  
38.32 including time limits for facility response; provides for the patient or resident to have the  
38.33 assistance of an advocate; requires a written response to written grievances; and provides  
38.34 for a timely decision by an impartial decision maker if the grievance is not otherwise resolved.

39.1 Compliance by hospitals, residential programs ~~as defined in section 253C.01~~ which are  
39.2 hospital-based primary treatment programs, and outpatient surgery centers with section  
39.3 144.691 and compliance by health maintenance organizations with section 62D.11 is deemed  
39.4 to be compliance with the requirement for a written internal grievance procedure.

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

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

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

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

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

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

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

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

39.27 **144A.07 FEES.**

39.28 Each application for a license to operate a nursing home, or for a renewal of license,  
39.29 except an application by the Minnesota Veterans Home or the ~~commissioner of human~~  
39.30 ~~services~~ Direct Care and Treatment executive board for the licensing of state institutions,

40.1 shall be accompanied by a fee to be prescribed by the commissioner of health pursuant to  
40.2 section 144.122. No fee shall be refunded.

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

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

40.5 Subd. 4. **Examination; access to medical data.** (a) If the commissioner has probable  
40.6 cause to believe that an unlicensed complementary and alternative health care practitioner  
40.7 has engaged in conduct prohibited by subdivision 1, paragraph (h), (i), (j), or (k), the  
40.8 commissioner may issue an order directing the practitioner to submit to a mental or physical  
40.9 examination or substance use disorder evaluation. For the purpose of this subdivision, every  
40.10 unlicensed complementary and alternative health care practitioner is deemed to have  
40.11 consented to submit to a mental or physical examination or substance use disorder evaluation  
40.12 when ordered to do so in writing by the commissioner and further to have waived all  
40.13 objections to the admissibility of the testimony or examination reports of the health care  
40.14 provider performing the examination or evaluation on the grounds that the same constitute  
40.15 a privileged communication. Failure of an unlicensed complementary and alternative health  
40.16 care practitioner to submit to an examination or evaluation when ordered, unless the failure  
40.17 was due to circumstances beyond the practitioner's control, constitutes an admission that  
40.18 the unlicensed complementary and alternative health care practitioner violated subdivision  
40.19 1, paragraph (h), (i), (j), or (k), based on the factual specifications in the examination or  
40.20 evaluation order and may result in a default and final disciplinary order being entered after  
40.21 a contested case hearing. An unlicensed complementary and alternative health care  
40.22 practitioner affected under this paragraph shall at reasonable intervals be given an opportunity  
40.23 to demonstrate that the practitioner can resume the provision of complementary and  
40.24 alternative health care practices with reasonable safety to clients. In any proceeding under  
40.25 this paragraph, neither the record of proceedings nor the orders entered by the commissioner  
40.26 shall be used against an unlicensed complementary and alternative health care practitioner  
40.27 in any other proceeding.

40.28 (b) In addition to ordering a physical or mental examination or substance use disorder  
40.29 evaluation, the commissioner may, notwithstanding section 13.384; 144.651; 595.02; or  
40.30 any other law limiting access to medical or other health data, obtain medical data and health  
40.31 records relating to an unlicensed complementary and alternative health care practitioner  
40.32 without the practitioner's consent if the commissioner has probable cause to believe that a  
40.33 practitioner has engaged in conduct prohibited by subdivision 1, paragraph (h), (i), (j), or  
40.34 (k). The medical data may be requested from a provider as defined in section 144.291,

41.1 subdivision 2, paragraph (i), an insurance company, or a government agency, including the  
41.2 Department of Human Services and Direct Care and Treatment. A provider, insurance  
41.3 company, or government agency shall comply with any written request of the commissioner  
41.4 under this subdivision and is not liable in any action for damages for releasing the data  
41.5 requested by the commissioner if the data are released pursuant to a written request under  
41.6 this subdivision, unless the information is false and the person or organization giving the  
41.7 information knew or had reason to believe the information was false. Information obtained  
41.8 under this subdivision is private data under section 13.41.

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

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

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

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

41.26 (b) In addition to ordering a physical or mental examination, the board may,  
41.27 notwithstanding section 13.384, 144.651, or any other law limiting access to medical or  
41.28 other health data, obtain medical data and health records relating to a regulated person or  
41.29 applicant without the person's or applicant's consent if the board has probable cause to  
41.30 believe that a regulated person comes under subdivision 1, paragraph (1). The medical data  
41.31 may be requested from a provider, as defined in section 144.291, subdivision 2, paragraph  
41.32 (i), an insurance company, or a government agency, including the Department of Human  
41.33 Services and Direct Care and Treatment. A provider, insurance company, or government  
41.34 agency shall comply with any written request of the board under this subdivision and is not

42.1 liable in any action for damages for releasing the data requested by the board if the data are  
42.2 released pursuant to a written request under this subdivision, unless the information is false  
42.3 and the provider giving the information knew, or had reason to believe, the information was  
42.4 false. Information obtained under this subdivision is classified as private under sections  
42.5 13.01 to 13.87.

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

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

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

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

42.29 The medical data may be requested from a provider, as defined in section 144.291,  
42.30 subdivision 2, paragraph (i), an insurance company, or a government agency, including the  
42.31 Department of Human Services and Direct Care and Treatment. A provider, insurance  
42.32 company, or government agency shall comply with any written request of the board under  
42.33 this subdivision and is not liable in any action for damages for releasing the data requested  
42.34 by the board if the data are released pursuant to a written request under this subdivision,

43.1 unless the information is false and the provider giving the information knew, or had reason  
43.2 to believe, the information was false. Information obtained under this subdivision is classified  
43.3 as private under chapter 13.

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

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

43.6 Subdivision 1. **Grounds.** (a) The state Board of Chiropractic Examiners may refuse to  
43.7 grant, or may revoke, suspend, condition, limit, restrict or qualify a license to practice  
43.8 chiropractic, or may cause the name of a person licensed to be removed from the records  
43.9 in the office of the court administrator of the district court for:

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

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

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

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

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

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

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

43.22 (8) advanced physical or mental disability;

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

43.27 (10) the violation of, or failure to comply with, the provisions of sections 148.01 to  
43.28 148.105, the rules of the state Board of Chiropractic Examiners, or a lawful order of the  
43.29 board;

43.30 (11) unprofessional conduct;

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

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

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

44.32 (13) aiding or abetting an unlicensed person in the practice of chiropractic, except that  
44.33 it is not a violation of this clause for a doctor of chiropractic to employ, supervise, or delegate  
44.34 functions to a qualified person who may or may not be required to obtain a license or

45.1 registration to provide health services if that person is practicing within the scope of the  
45.2 license or registration or delegated authority;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

46.22 (3) performing unnecessary services;

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

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

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

46.29 (7) advertising that the licensee will accept for services rendered assigned payments  
46.30 from any third-party payer as payment in full, if the effect is to give the impression of  
46.31 eliminating the need of payment by the patient of any required deductible or co-payment  
46.32 applicable in the patient's health benefit plan. As used in this clause, "advertise" means  
46.33 solicitation by the licensee by means of handbills, posters, circulars, motion pictures, radio,

47.1 newspapers, television, or in any other manner. In addition to the board's power to punish  
47.2 for violations of this clause, violation of this clause is also a misdemeanor;

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

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

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

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

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

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

47.27 (b) It may, notwithstanding sections 13.384, 144.651, 595.02, or any other law limiting  
47.28 access to medical or other health data, obtain medical data and health records relating to a  
47.29 registered nurse, advanced practice registered nurse, licensed practical nurse, or applicant  
47.30 for a license without that person's consent. The medical data may be requested from a  
47.31 provider, as defined in section 144.291, subdivision 2, paragraph (i), an insurance company,  
47.32 or a government agency, including the Department of Human Services and Direct Care and  
47.33 Treatment. A provider, insurance company, or government agency shall comply with any

48.1 written request of the board under this subdivision and is not liable in any action for damages  
48.2 for releasing the data requested by the board if the data are released pursuant to a written  
48.3 request under this subdivision unless the information is false and the provider giving the  
48.4 information knew, or had reason to believe, the information was false. Information obtained  
48.5 under this subdivision is classified as private data on individuals as defined in section 13.02.

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

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

48.8 **148.754 EXAMINATION; ACCESS TO MEDICAL DATA.**

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

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

48.24 (c) In addition to ordering a physical or mental examination, the board may,  
48.25 notwithstanding section 13.384, 144.651, or any other law limiting access to medical or  
48.26 other health data, obtain medical data and health records relating to a licensee or applicant  
48.27 without the person's or applicant's consent if the board has probable cause to believe that  
48.28 the person comes under paragraph (a). The medical data may be requested from a provider,  
48.29 as defined in section 144.291, subdivision 2, paragraph (i), an insurance company, or a  
48.30 government agency, including the Department of Human Services and Direct Care and  
48.31 Treatment. A provider, insurance company, or government agency shall comply with any  
48.32 written request of the board under this paragraph and is not liable in any action for damages  
48.33 for releasing the data requested by the board if the data are released pursuant to a written  
48.34 request under this paragraph, unless the information is false and the provider giving the

49.1 information knew, or had reason to believe, the information was false. Information obtained  
49.2 under this paragraph is classified as private under sections 13.01 to 13.87.

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

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

49.5 **148B.5905 MENTAL, PHYSICAL, OR SUBSTANCE USE DISORDER**  
49.6 **EXAMINATION OR EVALUATION; ACCESS TO MEDICAL DATA.**

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

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

50.1 the information was false. Information obtained under this subdivision is classified as private  
50.2 under sections 13.01 to 13.87.

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

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

50.5 Subd. 6. **Mental, physical, or chemical health evaluation.** (a) If the board has probable  
50.6 cause to believe that an applicant or licensee is unable to practice alcohol and drug counseling  
50.7 with reasonable skill and safety due to a mental or physical illness or condition, the board  
50.8 may direct the individual to submit to a mental, physical, or chemical dependency  
50.9 examination or evaluation.

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

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

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

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

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

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

51.1 (2) an insurance company; or

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

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

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

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

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

51.13 Subd. 6. **Medical records.** Notwithstanding contrary provisions of sections 13.384 and  
51.14 144.651 or any other statute limiting access to medical or other health data, the board may  
51.15 obtain medical data and health records of a licensee or applicant without the licensee's or  
51.16 applicant's consent if the information is requested by the board as part of the process specified  
51.17 in subdivision 5. The medical data may be requested from a provider, as defined in section  
51.18 144.291, subdivision 2, paragraph (h), an insurance company, or a government agency,  
51.19 including the Department of Human Services and Direct Care and Treatment. A provider,  
51.20 insurance company, or government agency shall comply with any written request of the  
51.21 board under this subdivision and shall not be liable in any action for damages for releasing  
51.22 the data requested by the board if the data are released pursuant to a written request under  
51.23 this subdivision, unless the information is false and the provider giving the information  
51.24 knew, or had reason to believe, the information was false. Information obtained under this  
51.25 subdivision shall be classified as private under the Minnesota Government Data Practices  
51.26 Act.

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

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

51.29 Subd. 10. **Mental examination; access to medical data.** (a) If the board receives a  
51.30 complaint and has probable cause to believe that an individual licensed or registered by the  
51.31 board falls under subdivision 2, clause (14), it may direct the individual to submit to a mental  
51.32 or physical examination. For the purpose of this subdivision, every licensed or registered

52.1 individual is deemed to have consented to submit to a mental or physical examination when  
52.2 directed in writing by the board and further to have waived all objections to the admissibility  
52.3 of the examining practitioner's testimony or examination reports on the grounds that the  
52.4 same constitute a privileged communication. Failure of a licensed or registered individual  
52.5 to submit to an examination when directed constitutes an admission of the allegations against  
52.6 the individual, unless the failure was due to circumstances beyond the individual's control,  
52.7 in which case a default and final order may be entered without the taking of testimony or  
52.8 presentation of evidence. Pharmacists affected under this paragraph shall at reasonable  
52.9 intervals be given an opportunity to demonstrate that they can resume the competent practice  
52.10 of the profession of pharmacy with reasonable skill and safety to the public. Pharmacist  
52.11 interns, pharmacy technicians, or controlled substance researchers affected under this  
52.12 paragraph shall at reasonable intervals be given an opportunity to demonstrate that they can  
52.13 competently resume the duties that can be performed, under this chapter or the rules of the  
52.14 board, by similarly registered persons with reasonable skill and safety to the public. In any  
52.15 proceeding under this paragraph, neither the record of proceedings nor the orders entered  
52.16 by the board shall be used against a licensed or registered individual in any other proceeding.

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

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

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

52.33 Subd. 2. **Access to medical data.** In addition to ordering a physical or mental examination  
52.34 or substance use disorder evaluation, the board may, notwithstanding section 13.384, 144.651,

53.1 or any other law limiting access to medical or other health data, obtain medical data and  
53.2 health records relating to a licensee or applicant without the licensee's or applicant's consent  
53.3 if the board has probable cause to believe that a doctor of podiatric medicine falls within  
53.4 the provisions of section 153.19, subdivision 1, clause (12). The medical data may be  
53.5 requested from a provider, as defined in section 144.291, subdivision 2, paragraph (h), an  
53.6 insurance company, or a government agency, including the Department of Human Services  
53.7 and Direct Care and Treatment. A provider, insurance company, or government agency  
53.8 shall comply with any written request of the board under this section and is not liable in  
53.9 any action for damages for releasing the data requested by the board if the data are released  
53.10 in accordance with a written request under this section, unless the information is false and  
53.11 the provider giving the information knew, or had reason to believe, the information was  
53.12 false.

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

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

53.15 **153B.70 GROUNDS FOR DISCIPLINARY ACTION.**

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

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

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

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

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

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

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

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

- 54.1 (8) engaging in dishonorable, unethical, or unprofessional conduct;
- 54.2 (9) engaging in conduct of a character likely to deceive, defraud, or harm the public;
- 54.3 (10) inability to practice due to habitual intoxication, addiction to drugs, or mental or  
54.4 physical illness;
- 54.5 (11) being disciplined by another state or territory of the United States, the federal  
54.6 government, a national certification organization, or foreign nation, if at least one of the  
54.7 grounds for the discipline is the same or substantially equivalent to one of the grounds in  
54.8 this section;
- 54.9 (12) directly or indirectly giving to or receiving from a person, firm, corporation,  
54.10 partnership, or association a fee, commission, rebate, or other form of compensation for  
54.11 professional services not actually or personally rendered;
- 54.12 (13) incurring a finding by the board that the licensee, after the licensee has been placed  
54.13 on probationary status, has violated the conditions of the probation;
- 54.14 (14) abandoning a patient or client;
- 54.15 (15) willfully making or filing false records or reports in the course of the licensee's  
54.16 practice including, but not limited to, false records or reports filed with state or federal  
54.17 agencies;
- 54.18 (16) willfully failing to report child maltreatment as required under the Maltreatment of  
54.19 Minors Act, chapter 260E; or
- 54.20 (17) soliciting professional services using false or misleading advertising.
- 54.21 (b) A license to practice is automatically suspended if (1) a guardian of a licensee is  
54.22 appointed by order of a court pursuant to sections 524.5-101 to 524.5-502, for reasons other  
54.23 than the minority of the licensee, or (2) the licensee is committed by order of a court pursuant  
54.24 to chapter 253B. The license remains suspended until the licensee is restored to capacity  
54.25 by a court and, upon petition by the licensee, the suspension is terminated by the board after  
54.26 a hearing. The licensee may be reinstated to practice, either with or without restrictions, by  
54.27 demonstrating clear and convincing evidence of rehabilitation. The regulated person is not  
54.28 required to prove rehabilitation if the subsequent court decision overturns previous court  
54.29 findings of public risk.
- 54.30 (c) If the board has probable cause to believe that a licensee or applicant has violated  
54.31 paragraph (a), clause (10), it may direct the person to submit to a mental or physical  
54.32 examination. For the purpose of this section, every person is deemed to have consented to

55.1 submit to a mental or physical examination when directed in writing by the board and to  
55.2 have waived all objections to the admissibility of the examining physician's testimony or  
55.3 examination report on the grounds that the testimony or report constitutes a privileged  
55.4 communication. Failure of a regulated person to submit to an examination when directed  
55.5 constitutes an admission of the allegations against the person, unless the failure was due to  
55.6 circumstances beyond the person's control, in which case a default and final order may be  
55.7 entered without the taking of testimony or presentation of evidence. A regulated person  
55.8 affected under this paragraph shall at reasonable intervals be given an opportunity to  
55.9 demonstrate that the person can resume the competent practice of the regulated profession  
55.10 with reasonable skill and safety to the public. In any proceeding under this paragraph, neither  
55.11 the record of proceedings nor the orders entered by the board shall be used against a regulated  
55.12 person in any other proceeding.

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

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

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

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

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

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

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

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

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

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

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

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

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

56.16 (1) vehicles owned by the federal government;

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

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

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

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

57.1 by the commissioner and state that the vehicle will be used exclusively for a purpose  
57.2 authorized by this section.

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

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

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

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

58.1 ~~director and the executive director's staff~~; and the Office of the Inspector General's staff,  
58.2 including, but not limited to, contract and county fraud prevention investigators.

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

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

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

58.31 ~~(j)~~ (k) Unmarked vehicles used in general investigation, surveillance, supervision, and  
58.32 monitoring by tobacco inspector staff of the Department of Human Services' Alcohol and  
58.33 Drug Abuse Division for the purposes of tobacco inspections, investigations, and reviews  
58.34 must be registered and must display passenger vehicle classification license number plates,  
58.35 furnished at cost by the registrar. Original and renewal applications for passenger vehicle

59.1 license plates must be accompanied by a certification signed by the commissioner of human  
59.2 services. The certification must be on a form prescribed by the commissioner and state that  
59.3 the vehicles will be used exclusively by tobacco inspector staff for the duties specified in  
59.4 this paragraph.

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

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

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

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

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

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

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

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

60.19 Notwithstanding the assignment of a predatory offender to risk level II or III, a law  
60.20 enforcement agency may not make the disclosures permitted or required by clause (2) or  
60.21 (3), if: the offender is placed or resides in a residential facility. However, if an offender is  
60.22 placed or resides in a residential facility, the offender and the head of the facility shall  
60.23 designate the offender's likely residence upon release from the facility and the head of the  
60.24 facility shall notify the commissioner of corrections ~~or~~, the commissioner of human services,  
60.25 or the Direct Care and Treatment executive board of the offender's likely residence at least  
60.26 14 days before the offender's scheduled release date. The commissioner shall give this  
60.27 information to the law enforcement agency having jurisdiction over the offender's likely  
60.28 residence. The head of the residential facility also shall notify the commissioner of corrections  
60.29 ~~or~~, the commissioner of human services, or the Direct Care and Treatment executive board  
60.30 within 48 hours after finalizing the offender's approved relocation plan to a permanent  
60.31 residence. Within five days after receiving this notification, the appropriate commissioner  
60.32 shall give to the appropriate law enforcement agency all relevant information the  
60.33 commissioner has concerning the offender, including information on the risk factors in the  
60.34 offender's history and the risk level to which the offender was assigned. After receiving this

61.1 information, the law enforcement agency shall make the disclosures permitted or required  
61.2 by clause (2) or (3), as appropriate.

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

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

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

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

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

61.19 (f) A law enforcement agency shall continue to disclose information on an offender as  
61.20 required by this subdivision for as long as the offender is required to register under section  
61.21 243.166. This requirement on a law enforcement agency to continue to disclose information  
61.22 also applies to an offender who lacks a primary address and is registering under section  
61.23 243.166, subdivision 3a.

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

61.29 (h) A city council may adopt a policy that addresses when information disclosed under  
61.30 this subdivision must be presented in languages in addition to English. The policy may  
61.31 address when information must be presented orally, in writing, or both in additional languages  
61.32 by the law enforcement agency disclosing the information. The policy may provide for

62.1 different approaches based on the prevalence of non-English languages in different  
62.2 neighborhoods.

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

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

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

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

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

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

62.27 (b) Unless prohibited by another law and subject to the exceptions listed in subdivision  
62.28 3, a county board ~~or~~, the commissioner of human services, or the Direct Care and Treatment  
62.29 executive board may contract with an agency or facility in a bordering state for mental  
62.30 health, chemical health, or detoxification services for residents of Minnesota, and a Minnesota  
62.31 mental health, chemical health, or detoxification agency or facility may contract to provide  
62.32 services to residents of bordering states. Except as provided in subdivision 5, a person who  
62.33 receives services in another state under this section is subject to the laws of the state in

63.1 which services are provided. A person who will receive services in another state under this  
63.2 section must be informed of the consequences of receiving services in another state, including  
63.3 the implications of the differences in state laws, to the extent the individual will be subject  
63.4 to the laws of the receiving state.

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

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

63.7 **245.52 COMMISSIONER OF HUMAN SERVICES AS COMPACT**  
63.8 **ADMINISTRATOR.**

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

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

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

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

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

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

64.2 **246.585 CRISIS SERVICES.**

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

64.12 (1) individual assessments;

64.13 (2) program plan development and implementation assistance;

64.14 (3) analysis of service delivery problems; and

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

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

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

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

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

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

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

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

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

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

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

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

65.14 **246C.20 CONTRACT WITH DEPARTMENT OF HUMAN SERVICES FOR**  
65.15 **ADMINISTRATIVE SERVICES.**

65.16 (a) Direct Care and Treatment shall contract with the Department of Human Services  
65.17 to provide determinations on issues of county of financial responsibility under chapter 256G  
65.18 and to provide administrative and judicial review of direct care and treatment matters  
65.19 according to section 256.045.

65.20 (b) The executive board may prescribe rules necessary to carry out this ~~subdivision~~  
65.21 section, except that the executive board must not create any rule purporting to control the  
65.22 decision making or processes of state human services judges under section 256.045,  
65.23 subdivision 4, or the decision making or processes of the commissioner of human services  
65.24 issuing an advisory opinion or recommended order to the executive board under section  
65.25 256G.09, subdivision 3. The executive board must not create any rule purporting to control  
65.26 processes for determinations of financial responsibility under chapter 256G or administrative  
65.27 and judicial review under section 256.045 on matters outside of the jurisdiction of Direct  
65.28 Care and Treatment.

65.29 (c) The executive board and commissioner of human services may adopt joint rules  
65.30 necessary to accomplish the purposes of this section.

66.1 Sec. 35. [246C.21] INTERVIEW EXPENSES.

66.2 Job applicants for professional, administrative, or highly technical positions recruited  
66.3 by the Direct Care and Treatment executive board may be reimbursed for necessary travel  
66.4 expenses to and from interviews arranged by the Direct Care and Treatment executive board.

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

66.6 Sec. 36. [246C.211] FEDERAL GRANTS FOR MINNESOTA INDIANS.

66.7 The Direct Care and Treatment executive board is authorized to enter into contracts with  
66.8 the United States Departments of Health and Human Services; Education; and Interior,  
66.9 Bureau of Indian Affairs, for the purposes of receiving federal grants for the welfare and  
66.10 relief of Minnesota Indians.

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

66.12 Sec. 37. Minnesota Statutes 2024, section 252.291, subdivision 3, is amended to read:

66.13 Subd. 3. **Duties of commissioner of human services.** The commissioner shall:

66.14 (1) ~~establish standard admission criteria for state hospitals and~~ county utilization targets  
66.15 to limit and reduce the number of intermediate care beds in state hospitals and community  
66.16 facilities in accordance with approved waivers under United States Code, title 42, sections  
66.17 1396 to 1396p, as amended through December 31, 1987, to ~~assure~~ ensure that appropriate  
66.18 services are provided in the least restrictive setting;

66.19 (2) define services, including respite care, that may be needed in meeting individual  
66.20 service plan objectives;

66.21 (3) provide technical assistance so that county boards may establish a request for proposal  
66.22 system for meeting individual service plan objectives through home and community-based  
66.23 services; alternative community services; or, if no other alternative will meet the needs of  
66.24 identifiable individuals for whom the county is financially responsible, a new intermediate  
66.25 care facility for persons with developmental disabilities;

66.26 (4) establish a client tracking and evaluation system as required under applicable federal  
66.27 waiver regulations, Code of Federal Regulations, title 42, sections 431, 435, 440, and 441,  
66.28 as amended through December 31, 1987; and

66.29 (5) develop a state plan for the delivery and funding of residential day and support  
66.30 services to persons with developmental disabilities in Minnesota. The biennial developmental  
66.31 disability plan shall include but not be limited to:

- 67.1 (i) county by county maximum intermediate care bed utilization quotas;
- 67.2 (ii) plans for the development of the number and types of services alternative to
- 67.3 intermediate care beds;
- 67.4 (iii) procedures for the administration and management of the plan;
- 67.5 (iv) procedures for the evaluation of the implementation of the plan; and
- 67.6 (v) the number, type, and location of intermediate care beds targeted for decertification.

67.7 The commissioner shall modify the plan to ensure conformance with the medical

67.8 assistance home and community-based services waiver.

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

67.10 Sec. 38. Minnesota Statutes 2024, section 252.50, subdivision 5, is amended to read:

67.11 Subd. 5. **Location of programs.** (a) In determining the location of state-operated,

67.12 community-based programs, the needs of the individual client shall be paramount. The

67.13 executive board shall also take into account:

67.14 (1) prioritization of ~~beds~~ services in state-operated, community-based programs for

67.15 individuals with complex behavioral needs that cannot be met by private community-based

67.16 providers;

67.17 (2) choices made by individuals who chose to move to a more integrated setting, and

67.18 shall coordinate with the lead agency to ensure that appropriate person-centered transition

67.19 plans are created;

67.20 (3) the personal preferences of the persons being served and their families as determined

67.21 by Minnesota Rules, parts 9525.0004 to 9525.0036;

67.22 (4) the location of the support services established by the individual service plans of the

67.23 persons being served;

67.24 (5) the appropriate grouping of the persons served;

67.25 (6) the availability of qualified staff;

67.26 (7) the need for state-operated, community-based programs in the geographical region

67.27 of the state; and

67.28 (8) a reasonable commuting distance from a regional treatment center or the residences

67.29 of the program staff.

68.1 (b) The executive board must locate state-operated, community-based programs in  
68.2 coordination with the commissioner of human services according to section 252.28.

68.3 Sec. 39. Minnesota Statutes 2024, section 253B.07, subdivision 2b, is amended to read:

68.4 Subd. 2b. **Apprehend and hold orders.** (a) The court may order the treatment facility  
68.5 or state-operated treatment program to hold the proposed patient or direct a health officer,  
68.6 peace officer, or other person to take the proposed patient into custody and transport the  
68.7 proposed patient to a treatment facility or state-operated treatment program for observation,  
68.8 evaluation, diagnosis, care, treatment, and, if necessary, confinement, when:

68.9 (1) there has been a particularized showing by the petitioner that serious physical harm  
68.10 to the proposed patient or others is likely unless the proposed patient is immediately  
68.11 apprehended;

68.12 (2) the proposed patient has not voluntarily appeared for the examination or the  
68.13 commitment hearing pursuant to the summons; or

68.14 (3) a person is held pursuant to section 253B.051 and a request for a petition for  
68.15 commitment has been filed.

68.16 (b) The order of the court may be executed on any day and at any time by the use of all  
68.17 necessary means including the imposition of necessary restraint upon the proposed patient.  
68.18 Where possible, a peace officer taking the proposed patient into custody pursuant to this  
68.19 subdivision shall not be in uniform and shall not use a vehicle visibly marked as a law  
68.20 enforcement vehicle. Except as provided in section 253D.10, subdivision 2, in the case of  
68.21 an individual on a judicial hold due to a petition for civil commitment under chapter 253D,  
68.22 assignment of custody during the hold is to the ~~commissioner~~ executive board. The  
68.23 ~~commissioner~~ executive board is responsible for determining the appropriate placement  
68.24 within a secure treatment facility under the authority of the ~~commissioner~~ executive board.

68.25 (c) A proposed patient must not be allowed or required to consent to nor participate in  
68.26 a clinical drug trial while an order is in effect under this subdivision. A consent given while  
68.27 an order is in effect is void and unenforceable. This paragraph does not prohibit a patient  
68.28 from continuing participation in a clinical drug trial if the patient was participating in the  
68.29 clinical drug trial at the time the order was issued under this subdivision.

68.30 Sec. 40. Minnesota Statutes 2024, section 253B.09, subdivision 3a, is amended to read:

68.31 Subd. 3a. **Reporting judicial commitments; private treatment program or**  
68.32 **facility.** Notwithstanding section 253B.23, subdivision 9, when a court commits a patient

69.1 to a non-state-operated treatment facility or program, the court shall report the commitment  
69.2 to the ~~commissioner~~ executive board through the supreme court information system for  
69.3 purposes of providing commitment information for firearm background checks under section  
69.4 246C.15. If the patient is committed to a state-operated treatment program, the court shall  
69.5 send a copy of the commitment order to ~~the commissioner~~ and the executive board.

69.6 Sec. 41. Minnesota Statutes 2024, section 253B.10, subdivision 1, is amended to read:

69.7 Subdivision 1. **Administrative requirements.** (a) When a person is committed, the  
69.8 court shall issue a warrant or an order committing the patient to the custody of the head of  
69.9 the treatment facility, state-operated treatment program, or community-based treatment  
69.10 program. The warrant or order shall state that the patient meets the statutory criteria for  
69.11 civil commitment.

69.12 (b) The executive board shall prioritize civilly committed patients being admitted from  
69.13 jail or a correctional institution or who are referred to a state-operated treatment facility for  
69.14 competency attainment or a competency examination under sections 611.40 to 611.59 for  
69.15 admission to a medically appropriate state-operated direct care and treatment bed based on  
69.16 the decisions of physicians in the executive medical director's office, using a priority  
69.17 admissions framework. The framework must account for a range of factors for priority  
69.18 admission, including but not limited to:

69.19 (1) the length of time the person has been on a waiting list for admission to a  
69.20 state-operated direct care and treatment program since the date of the order under paragraph  
69.21 (a), or the date of an order issued under sections 611.40 to 611.59;

69.22 (2) the intensity of the treatment the person needs, based on medical acuity;

69.23 (3) the person's revoked provisional discharge status;

69.24 (4) the person's safety and safety of others in the person's current environment;

69.25 (5) whether the person has access to necessary or court-ordered treatment;

69.26 (6) distinct and articulable negative impacts of an admission delay on the facility referring  
69.27 the individual for treatment; and

69.28 (7) any relevant federal prioritization requirements.

69.29 Patients described in this paragraph must be admitted to a state-operated treatment program  
69.30 within 48 hours. The commitment must be ordered by the court as provided in section  
69.31 253B.09, subdivision 1, paragraph (d). Patients committed to a secure treatment facility or  
69.32 less restrictive setting as ordered by the court under section 253B.18, subdivisions 1 and 2,

70.1 must be prioritized for admission to a state-operated treatment program using the priority  
70.2 admissions framework in this paragraph.

70.3 (c) Upon the arrival of a patient at the designated treatment facility, state-operated  
70.4 treatment program, or community-based treatment program, the head of the facility or  
70.5 program shall retain the duplicate of the warrant and endorse receipt upon the original  
70.6 warrant or acknowledge receipt of the order. The endorsed receipt or acknowledgment must  
70.7 be filed in the court of commitment. After arrival, the patient shall be under the control and  
70.8 custody of the head of the facility or program.

70.9 (d) Copies of the petition for commitment, the court's findings of fact and conclusions  
70.10 of law, the court order committing the patient, the report of the court examiners, and the  
70.11 prepetition report, and any medical and behavioral information available shall be provided  
70.12 at the time of admission of a patient to the designated treatment facility or program to which  
70.13 the patient is committed. Upon a patient's referral to the executive board for admission  
70.14 pursuant to subdivision 1, paragraph (b), any inpatient hospital, treatment facility, jail, or  
70.15 correctional facility that has provided care or supervision to the patient in the previous two  
70.16 years shall, when requested by the treatment facility or executive board, provide copies of  
70.17 the patient's medical and behavioral records to the executive board for purposes of  
70.18 preadmission planning. This information shall be provided by the head of the treatment  
70.19 facility to treatment facility staff in a consistent and timely manner and pursuant to all  
70.20 applicable laws.

70.21 (e) Patients described in paragraph (b) must be admitted to a state-operated treatment  
70.22 program within 48 hours of the Office of Executive Medical Director, under section 246C.09,  
70.23 or a designee determining that a medically appropriate bed is available. This paragraph  
70.24 ~~expires on June 30, 2025.~~ expires on June 30, 2027.

70.25 (f) Within four business days of determining which state-operated direct care and  
70.26 treatment program or programs are appropriate for an individual, the executive medical  
70.27 director's office or a designee must notify the source of the referral and the responsible  
70.28 county human services agency, the individual being ordered to direct care and treatment,  
70.29 and the district court that issued the order of the determination. The notice shall include  
70.30 which program or programs are appropriate for the person's priority status. Any interested  
70.31 person may provide additional information or request updated priority status about the  
70.32 individual to the executive medical director's office or a designee while the individual is  
70.33 awaiting admission. Updated priority status of an individual will only be disclosed to  
70.34 interested persons who are legally authorized to receive private information about the  
70.35 individual. When an available bed has been identified, the executive medical director's

71.1 office or a designee must notify the designated agency and the facility where the individual  
71.2 is awaiting admission that the individual has been accepted for admission to a particular  
71.3 state-operated direct care and treatment program and the earliest possible date the admission  
71.4 can occur. The designated agency or facility where the individual is awaiting admission  
71.5 must transport the individual to the admitting state-operated direct care and treatment  
71.6 program no more than 48 hours after the offered admission date.

71.7 Sec. 42. Minnesota Statutes 2024, section 253B.141, subdivision 2, is amended to read:

71.8 Subd. 2. **Apprehension; return to facility or program.** (a) Upon receiving the report  
71.9 of absence from the head of the treatment facility, state-operated treatment program, or  
71.10 community-based treatment program or the committing court, a patient may be apprehended  
71.11 and held by a peace officer in any jurisdiction pending return to the facility or program from  
71.12 which the patient is absent without authorization. A patient may also be returned to any  
71.13 state-operated treatment program or any other treatment facility or community-based  
71.14 treatment program willing to accept the person. A person who has a mental illness and is  
71.15 dangerous to the public and detained under this subdivision may be held in a jail or lockup  
71.16 only if:

71.17 (1) there is no other feasible place of detention for the patient;

71.18 (2) the detention is for less than 24 hours; and

71.19 (3) there are protections in place, including segregation of the patient, to ensure the  
71.20 safety of the patient.

71.21 (b) If a patient is detained under this subdivision, the head of the facility or program  
71.22 from which the patient is absent shall arrange to pick up the patient within 24 hours of the  
71.23 time detention was begun and shall be responsible for securing transportation for the patient  
71.24 to the facility or program. The expense of detaining and transporting a patient shall be the  
71.25 responsibility of the facility or program from which the patient is absent. The expense of  
71.26 detaining and transporting a patient to a state-operated treatment program shall be paid by  
71.27 the ~~commissioner~~ executive board unless paid by the patient or persons on behalf of the  
71.28 patient.

71.29 Sec. 43. Minnesota Statutes 2024, section 253B.18, subdivision 6, is amended to read:

71.30 Subd. 6. **Transfer.** (a) A patient who is a person who has a mental illness and is  
71.31 dangerous to the public shall not be transferred out of a secure treatment facility unless it  
71.32 appears to the satisfaction of the executive board, after a hearing and favorable

72.1 recommendation by a majority of the special review board, that the transfer is appropriate.  
72.2 Transfer may be to another state-operated treatment program. In those instances where a  
72.3 commitment also exists to the Department of Corrections, transfer may be to a facility  
72.4 designated by the commissioner of corrections.

72.5 (b) The following factors must be considered in determining whether a transfer is  
72.6 appropriate:

72.7 (1) the person's clinical progress and present treatment needs;

72.8 (2) the need for security to accomplish continuing treatment;

72.9 (3) the need for continued institutionalization;

72.10 (4) which facility can best meet the person's needs; and

72.11 (5) whether transfer can be accomplished with a reasonable degree of safety for the  
72.12 public.

72.13 (c) If a committed person has been transferred out of a secure treatment facility pursuant  
72.14 to this subdivision, that committed person may voluntarily return to a secure treatment  
72.15 facility for a period of up to 60 days with the consent of the head of the treatment facility.

72.16 (d) If the committed person is not returned to the original, nonsecure transfer facility  
72.17 within 60 days of being readmitted to a secure treatment facility, the transfer is revoked and  
72.18 the committed person must remain in a secure treatment facility. The committed person  
72.19 must immediately be notified in writing of the revocation.

72.20 (e) Within 15 days of receiving notice of the revocation, the committed person may  
72.21 petition the special review board for a review of the revocation. The special review board  
72.22 shall review the circumstances of the revocation and shall recommend to the ~~commissioner~~  
72.23 executive board whether or not the revocation should be upheld. The special review board  
72.24 may also recommend a new transfer at the time of the revocation hearing.

72.25 (f) No action by the special review board is required if the transfer has not been revoked  
72.26 and the committed person is returned to the original, nonsecure transfer facility with no  
72.27 substantive change to the conditions of the transfer ordered under this subdivision.

72.28 (g) The head of the treatment facility may revoke a transfer made under this subdivision  
72.29 and require a committed person to return to a secure treatment facility if:

72.30 (1) remaining in a nonsecure setting does not provide a reasonable degree of safety to  
72.31 the committed person or others; or

73.1 (2) the committed person has regressed clinically and the facility to which the committed  
73.2 person was transferred does not meet the committed person's needs.

73.3 (h) Upon the revocation of the transfer, the committed person must be immediately  
73.4 returned to a secure treatment facility. A report documenting the reasons for revocation  
73.5 must be issued by the head of the treatment facility within seven days after the committed  
73.6 person is returned to the secure treatment facility. Advance notice to the committed person  
73.7 of the revocation is not required.

73.8 (i) The committed person must be provided a copy of the revocation report and informed,  
73.9 orally and in writing, of the rights of a committed person under this section. The revocation  
73.10 report must be served upon the committed person, the committed person's counsel, and the  
73.11 designated agency. The report must outline the specific reasons for the revocation, including  
73.12 but not limited to the specific facts upon which the revocation is based.

73.13 (j) If a committed person's transfer is revoked, the committed person may re-petition for  
73.14 transfer according to subdivision 5.

73.15 (k) A committed person aggrieved by a transfer revocation decision may petition the  
73.16 special review board within seven business days after receipt of the revocation report for a  
73.17 review of the revocation. The matter must be scheduled within 30 days. The special review  
73.18 board shall review the circumstances leading to the revocation and, after considering the  
73.19 factors in paragraph (b), shall recommend to the ~~commissioner~~ executive board whether or  
73.20 not the revocation shall be upheld. The special review board may also recommend a new  
73.21 transfer out of a secure treatment facility at the time of the revocation hearing.

73.22 Sec. 44. Minnesota Statutes 2024, section 253B.19, subdivision 2, is amended to read:

73.23 Subd. 2. **Petition; hearing.** (a) A patient committed as a person who has a mental illness  
73.24 and is dangerous to the public under section 253B.18, or the county attorney of the county  
73.25 from which the patient was committed or the county of financial responsibility, may petition  
73.26 the judicial appeal panel for a rehearing and reconsideration of a decision by the  
73.27 ~~commissioner~~ executive board under section 253B.18, subdivision 5. The judicial appeal  
73.28 panel must not consider petitions for relief other than those considered by the executive  
73.29 board from which the appeal is taken. The petition must be filed with the supreme court  
73.30 within 30 days after the decision of the executive board is signed. The hearing must be held  
73.31 within 45 days of the filing of the petition unless an extension is granted for good cause.

73.32 (b) For an appeal under paragraph (a), the supreme court shall refer the petition to the  
73.33 chief judge of the judicial appeal panel. The chief judge shall notify the patient, the county

74.1 attorney of the county of commitment, the designated agency, the executive board, the head  
74.2 of the facility or program to which the patient was committed, any interested person, and  
74.3 other persons the chief judge designates, of the time and place of the hearing on the petition.  
74.4 The notice shall be given at least 14 days prior to the date of the hearing.

74.5 (c) Any person may oppose the petition. The patient, the patient's counsel, the county  
74.6 attorney of the committing county or the county of financial responsibility, and the executive  
74.7 board shall participate as parties to the proceeding pending before the judicial appeal panel  
74.8 and shall, except when the patient is committed solely as a person who has a mental illness  
74.9 and is dangerous to the public, no later than 20 days before the hearing on the petition,  
74.10 inform the judicial appeal panel and the opposing party in writing whether they support or  
74.11 oppose the petition and provide a summary of facts in support of their position. The judicial  
74.12 appeal panel may appoint court examiners and may adjourn the hearing from time to time.  
74.13 It shall hear and receive all relevant testimony and evidence and make a record of all  
74.14 proceedings. The patient, the patient's counsel, and the county attorney of the committing  
74.15 county or the county of financial responsibility have the right to be present and may present  
74.16 and cross-examine all witnesses and offer a factual and legal basis in support of their  
74.17 positions. The petitioning party seeking discharge or provisional discharge bears the burden  
74.18 of going forward with the evidence, which means presenting a prima facie case with  
74.19 competent evidence to show that the person is entitled to the requested relief. If the petitioning  
74.20 party has met this burden, the party opposing discharge or provisional discharge bears the  
74.21 burden of proof by clear and convincing evidence that the discharge or provisional discharge  
74.22 should be denied. A party seeking transfer under section 253B.18, subdivision 6, must  
74.23 establish by a preponderance of the evidence that the transfer is appropriate.

74.24 Sec. 45. Minnesota Statutes 2024, section 253D.14, subdivision 3, is amended to read:

74.25 Subd. 3. **Notice of discharge or release.** Before provisionally discharging, discharging,  
74.26 ~~granting pass-eligible status, approving a pass plan,~~ or otherwise permanently or temporarily  
74.27 releasing a person committed under this chapter from a treatment facility, the executive  
74.28 director shall make a reasonable effort to notify any victim of a crime for which the person  
74.29 was convicted that the person may be discharged or released and that the victim has a right  
74.30 to submit a written statement regarding decisions of the executive director, or ~~special review~~  
74.31 ~~board~~ judicial appeal panel, with respect to the person. To the extent possible, the notice  
74.32 must be provided at least 14 days before any ~~special review board~~ judicial appeal panel  
74.33 hearing ~~or before a determination on a pass plan~~. Notwithstanding section 611A.06,  
74.34 subdivision 4, the executive board shall provide the judicial appeal panel with victim  
74.35 information in order to comply with the provisions of this chapter. The judicial appeal panel

75.1 shall ensure that the data on victims remains private as provided for in section 611A.06,  
75.2 subdivision 4. This subdivision applies only to victims who have submitted a written request  
75.3 for notification as provided in subdivision 2a.

75.4 Sec. 46. Minnesota Statutes 2024, section 253D.27, subdivision 2, is amended to read:

75.5 Subd. 2. **Filing.** A petition for a reduction in custody or an appeal of a revocation of  
75.6 provisional discharge or revocation of transfer to a nonsecure facility may be filed by either  
75.7 the committed person or by the executive director and must be filed with and considered  
75.8 by ~~a panel of the special review board authorized under section 253B.18, subdivision 4~~  
75.9 judicial appeal panel established under section 253B.19, subdivision 1. A committed person  
75.10 may not petition the ~~special review board~~ judicial appeal panel any sooner than six months  
75.11 following either:

75.12 (1) the entry of judgment in the district court of the order for commitment issued under  
75.13 section 253D.07, subdivision 5, or upon the exhaustion of all related appeal rights in state  
75.14 court relating to that order, whichever is later; or

75.15 (2) any ~~recommendation of the special review board~~ or order of the judicial appeal panel,  
75.16 or upon the exhaustion of all appeal rights in state court, whichever is later. The executive  
75.17 director may petition at any time. ~~The special review board proceedings are not contested~~  
75.18 ~~cases as defined in chapter 14.~~

75.19 Sec. 47. Minnesota Statutes 2024, section 253D.28, is amended to read:

75.20 **253D.28 JUDICIAL APPEAL PANEL.**

75.21 Subdivision 1. **Rehearing and reconsideration.** (a) A person committed as a sexually  
75.22 dangerous person or a person with a sexual psychopathic personality under this chapter, or  
75.23 committed as both mentally ill and dangerous to the public under section 253B.18 and as  
75.24 a sexually dangerous person or a person with a sexual psychopathic personality under this  
75.25 chapter; the county attorney of the county from which the person was committed or the  
75.26 county of financial responsibility; or the executive board may petition the judicial appeal  
75.27 panel established under section 253B.19, subdivision 1, for a ~~rehearing and reconsideration~~  
75.28 ~~of a recommendation of the special review board under section 253D.27~~ reduction in custody.

75.29 (b) ~~The petition must be filed with the supreme court within 30 days after the~~  
75.30 ~~recommendation is mailed by the executive board as required in section 253D.27, subdivision~~  
75.31 ~~4.~~ The hearing must be held within 180 days of the filing of the petition unless an extension  
75.32 is granted for good cause.

76.1 ~~(e) If no party petitions the judicial appeal panel for a rehearing or reconsideration within~~  
76.2 ~~30 days, the judicial appeal panel shall either issue an order adopting the recommendations~~  
76.3 ~~of the special review board or set the matter on for a hearing pursuant to this section.~~

76.4 Subd. 2. **Procedure.** ~~(a) The supreme court shall refer a petition for rehearing and~~  
76.5 ~~reconsideration to the chief judge of the judicial appeal panel. The chief judge shall~~ Upon  
76.6 receiving a petition for reduction in custody, the chief judge of the judicial appeal panel  
76.7 shall schedule a hearing and notify the committing court, the committed person, the county  
76.8 attorneys of the county of commitment and county of financial responsibility, the executive  
76.9 board, the executive director, any interested person, and other persons the chief judge  
76.10 designates, of the time and place of the hearing on the petition. The notice shall be given  
76.11 at least 14 days prior to the date of the hearing. The hearing may be conducted by interactive  
76.12 video conference under General Rules of Practice, rule 131, and Minnesota Rules of Civil  
76.13 Commitment, rule 14.

76.14 ~~(b) Any person may oppose the petition.~~ The committed person, the committed person's  
76.15 counsel, the county attorneys of the committing county and county of financial responsibility,  
76.16 and the executive board shall participate as parties to the proceeding pending before the  
76.17 judicial appeal panel and shall, no later than 20 days before the hearing on the petition,  
76.18 inform the judicial appeal panel and the opposing party in writing whether they support or  
76.19 oppose the petition and provide a summary of facts in support of their position.

76.20 (c) The judicial appeal panel may appoint court examiners and may adjourn the hearing  
76.21 from time to time. It shall hear and receive all relevant testimony and evidence and make  
76.22 a record of all proceedings. The committed person, the committed person's counsel, ~~and~~ the  
76.23 county attorney of the committing county or the county of financial responsibility, and the  
76.24 executive board have the right to be present and may present and cross-examine all witnesses  
76.25 and offer a factual and legal basis in support of their positions.

76.26 (d) The petitioning party seeking discharge under section 253D.31 or provisional  
76.27 discharge under section 253D.30 bears the burden of going forward with the evidence,  
76.28 which means presenting a prima facie case with competent evidence to show that the person  
76.29 is entitled to the requested relief. If the petitioning party has met this burden, the party  
76.30 opposing discharge or provisional discharge bears the burden of proof by clear and  
76.31 convincing evidence that the discharge or provisional discharge should be denied.

76.32 (e) A party seeking transfer under section 253D.29 must establish by a preponderance  
76.33 of the evidence that the transfer is appropriate.

77.1 Subd. 3. **Decision.** A majority of the judicial appeal panel shall rule upon the petition.  
77.2 ~~The panel shall consider the petition de novo.~~ No order of the judicial appeal panel granting  
77.3 a transfer, discharge, or provisional discharge shall be made effective sooner than 15 days  
77.4 after it is issued. ~~The panel may not consider petitions for relief other than those considered~~  
77.5 ~~by the special review board from which the appeal is taken. The judicial appeal panel may~~  
77.6 ~~not grant a transfer or provisional discharge on terms or conditions that were not presented~~  
77.7 ~~to the special review board.~~

77.8 Subd. 4. **Appeal.** A party aggrieved by an order of the judicial appeal panel may appeal  
77.9 that order as provided under section 253B.19, subdivision 5.

77.10 Sec. 48. Minnesota Statutes 2024, section 253D.29, subdivision 1, is amended to read:

77.11 Subdivision 1. **Factors.** (a) A person who is committed as a sexually dangerous person  
77.12 or a person with a sexual psychopathic personality shall not be transferred out of a secure  
77.13 treatment facility unless the transfer is appropriate. Transfer may be to ~~other treatment~~  
77.14 ~~programs~~ a facility under the control of the executive board.

77.15 (b) The following factors must be considered in determining whether a transfer is  
77.16 appropriate:

77.17 (1) the person's clinical progress and present treatment needs;

77.18 (2) the need for security to accomplish continuing treatment;

77.19 (3) the need for continued institutionalization;

77.20 (4) which ~~other treatment program~~ facility can best meet the person's needs; and

77.21 (5) whether transfer can be accomplished with a reasonable degree of safety for the  
77.22 public.

77.23 Sec. 49. Minnesota Statutes 2024, section 253D.29, subdivision 2, is amended to read:

77.24 Subd. 2. **Voluntary readmission to a secure treatment facility.** (a) After a committed  
77.25 person has been transferred out of a secure treatment facility pursuant to subdivision 1 and  
77.26 with the consent of the executive director, a committed person may voluntarily return to a  
77.27 secure treatment facility for a period of up to 60 days.

77.28 (b) If the committed person is not returned to the ~~other treatment program~~ secure treatment  
77.29 facility to which the person was originally transferred pursuant to subdivision 1 within 60  
77.30 days of being readmitted to a secure treatment facility under this subdivision, the transfer  
77.31 to the ~~other treatment program~~ secure treatment facility under subdivision 1 is revoked and

78.1 the committed person shall remain in a secure treatment facility. The committed person  
78.2 shall immediately be notified in writing of the revocation.

78.3 (c) Within 15 days of receiving notice of the revocation, the committed person may  
78.4 petition the ~~special review board~~ judicial appeal panel for a review of the revocation. The  
78.5 ~~special review board~~ judicial appeal panel shall review the circumstances of the revocation  
78.6 and ~~shall recommend to the judicial appeal panel~~ determine whether ~~or not~~ the revocation  
78.7 shall be upheld. The ~~special review board~~ judicial appeal panel may also ~~recommend~~ grant  
78.8 a new transfer at the time of the revocation hearing.

78.9 (d) If the transfer has not been revoked and the committed person is to be returned to  
78.10 the ~~other treatment program~~ facility to which the committed person was originally transferred  
78.11 pursuant to subdivision 1 with no substantive change to the conditions of the transfer ordered  
78.12 pursuant to subdivision 1, no action by the ~~special review board~~ or judicial appeal panel is  
78.13 required.

78.14 Sec. 50. Minnesota Statutes 2024, section 253D.29, subdivision 3, is amended to read:

78.15 Subd. 3. **Revocation.** (a) The executive director may revoke a transfer made pursuant  
78.16 to subdivision 1 and require a committed person to return to a secure treatment facility if:

78.17 (1) remaining in a nonsecure setting will not provide a reasonable degree of safety to  
78.18 the committed person or others; or

78.19 (2) the committed person has regressed in clinical progress so that the ~~other treatment~~  
78.20 ~~program~~ facility to which the committed person was transferred is no longer sufficient to  
78.21 meet the committed person's needs.

78.22 (b) Upon the revocation of the transfer, the committed person shall be immediately  
78.23 returned to a secure treatment facility. A report documenting reasons for revocation shall  
78.24 be issued by the executive director within seven days after the committed person is returned  
78.25 to the secure treatment facility. Advance notice to the committed person of the revocation  
78.26 is not required.

78.27 (c) The committed person must be provided a copy of the revocation report and informed,  
78.28 orally and in writing, of the rights of a committed person under this section. The revocation  
78.29 report shall be served upon the committed person and the committed person's counsel. The  
78.30 report shall outline the specific reasons for the revocation including, but not limited to, the  
78.31 specific facts upon which the revocation is based.

78.32 (d) If a committed person's transfer is revoked, the committed person may re-petition  
78.33 for transfer according to section 253D.27.

79.1 (e) Any committed person aggrieved by a transfer revocation decision may petition the  
79.2 ~~special review board~~ judicial appeal panel within seven days, exclusive of Saturdays,  
79.3 Sundays, and legal holidays, after receipt of the revocation report for a review of the  
79.4 revocation. The matter shall be scheduled within 30 days. The ~~special review board~~ judicial  
79.5 appeal panel shall review the circumstances leading to the revocation and, after considering  
79.6 the factors in subdivision 1, paragraph (b), shall ~~recommend to the judicial appeal panel~~  
79.7 determine whether ~~or not~~ the revocation shall be upheld. The ~~special review board~~ judicial  
79.8 appeal panel may also ~~recommend~~ grant a new transfer out of a secure treatment facility at  
79.9 the time of the revocation hearing.

79.10 Sec. 51. Minnesota Statutes 2024, section 253D.30, subdivision 3, is amended to read:

79.11 Subd. 3. **Review.** A provisional discharge pursuant to this chapter shall not automatically  
79.12 terminate. A full discharge shall occur only as provided in section 253D.31. The terms of  
79.13 a provisional discharge continue unless the committed person requests and is granted a  
79.14 change in the conditions of provisional discharge or unless the committed person petitions  
79.15 the ~~special review board~~ judicial appeal panel for a full discharge and the discharge is granted  
79.16 ~~by the judicial appeal panel~~.

79.17 Sec. 52. Minnesota Statutes 2024, section 253D.30, subdivision 4, is amended to read:

79.18 Subd. 4. **Voluntary readmission.** (a) With the consent of the executive director, a  
79.19 committed person may voluntarily return to ~~the Minnesota Sex Offender Program~~ a secure  
79.20 treatment facility from provisional discharge for a period of up to 60 days.

79.21 (b) If the committed person is not returned to provisional discharge status within 60 days  
79.22 of being readmitted to ~~the Minnesota Sex Offender Program~~ a secure treatment facility, the  
79.23 provisional discharge is revoked. The committed person shall immediately be notified of  
79.24 the revocation in writing. Within 15 days of receiving notice of the revocation, the committed  
79.25 person may request a review of the matter before the ~~special review board~~ judicial appeal  
79.26 panel. The ~~special review board~~ judicial appeal panel shall review the circumstances of the  
79.27 revocation and, after applying the standards in subdivision 5, paragraph (a), shall ~~recommend~~  
79.28 ~~to the judicial appeal panel~~ determine whether ~~or not~~ the revocation shall be upheld. The  
79.29 ~~board~~ judicial appeal panel may ~~recommend~~ grant a return to provisional discharge status.

79.30 (c) If the provisional discharge has not been revoked and the committed person is to be  
79.31 returned to provisional discharge, ~~the Minnesota Sex Offender Program is not required to~~  
79.32 ~~petition for a further review by the special review board~~ no action by the judicial appeal

80.1 panel is required unless the committed person's return to the community results in substantive  
80.2 change to the existing provisional discharge plan.

80.3 Sec. 53. Minnesota Statutes 2024, section 253D.30, subdivision 5, is amended to read:

80.4 Subd. 5. **Revocation.** (a) The executive director may revoke a provisional discharge if  
80.5 either of the following grounds exist:

80.6 (1) the committed person has departed from the conditions of the provisional discharge  
80.7 plan; or

80.8 (2) the committed person is exhibiting behavior which may be dangerous to self or  
80.9 others.

80.10 (b) The executive director may revoke the provisional discharge and, either orally or in  
80.11 writing, order that the committed person be immediately returned to a secure treatment  
80.12 facility ~~or other treatment program~~. A report documenting reasons for revocation shall be  
80.13 issued by the executive director within seven days after the committed person is returned  
80.14 to the secure treatment facility ~~or other treatment program~~. Advance notice to the committed  
80.15 person of the revocation is not required.

80.16 (c) The committed person must be provided a copy of the revocation report and informed,  
80.17 orally and in writing, of the rights of a committed person under this section. The revocation  
80.18 report shall be served upon the committed person, the committed person's counsel, and the  
80.19 county attorneys of the county of commitment and the county of financial responsibility.  
80.20 The report shall outline the specific reasons for the revocation, including but not limited to  
80.21 the specific facts upon which the revocation is based.

80.22 (d) An individual who is revoked from provisional discharge must successfully re-petition  
80.23 the ~~special review board~~ and judicial appeal panel prior to being placed back on provisional  
80.24 discharge.

80.25 Sec. 54. Minnesota Statutes 2024, section 253D.30, subdivision 6, is amended to read:

80.26 Subd. 6. **Appeal.** Any committed person aggrieved by a revocation decision or any  
80.27 interested person may petition the ~~special review board~~ judicial appeal panel within seven  
80.28 days, exclusive of Saturdays, Sundays, and legal holidays, after receipt of the revocation  
80.29 report for a review of the revocation. The matter shall be scheduled within 30 days. The  
80.30 ~~special review board~~ judicial appeal panel shall review the circumstances leading to the  
80.31 revocation and shall ~~recommend to the judicial appeal panel~~ determine whether ~~or not~~ the

81.1 revocation shall be upheld. The special review board may also ~~recommend~~ grant a new  
81.2 provisional discharge at the time of the revocation hearing.

81.3 Sec. 55. Minnesota Statutes 2024, section 253D.31, is amended to read:

81.4 **253D.31 DISCHARGE.**

81.5 A person who is committed as a sexually dangerous person or a person with a sexual  
81.6 psychopathic personality shall not be discharged unless it appears to the satisfaction of the  
81.7 judicial appeal panel, ~~after a hearing and recommendation by a majority of the special review~~  
81.8 ~~board~~, that the committed person is capable of making an acceptable adjustment to open  
81.9 society, is no longer dangerous to the public, and is no longer in need of treatment and  
81.10 supervision.

81.11 In determining whether a discharge shall be ~~recommended~~ granted, the ~~special review~~  
81.12 ~~board~~ and judicial appeal panel shall consider whether specific conditions exist to provide  
81.13 a reasonable degree of protection to the public and to assist the committed person in adjusting  
81.14 to the community. If the desired conditions do not exist, the discharge shall not be granted.

81.15 Sec. 56. Minnesota Statutes 2024, section 256.01, subdivision 2, is amended to read:

81.16 Subd. 2. **Specific powers.** Subject to the provisions of section 241.021, subdivision 2,  
81.17 the commissioner of human services shall carry out the specific duties in paragraphs (a)  
81.18 through (bb):

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

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

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

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

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

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

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

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

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

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

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

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

82.31 (e) Act as the agent of and cooperate with the federal government in matters of mutual  
82.32 concern relative to and in conformity with the provisions of Laws 1939, chapter 431,  
82.33 including the administration of any federal funds granted to the state to aid in the performance

83.1 of any functions of the commissioner as specified in Laws 1939, chapter 431, and including  
83.2 the promulgation of rules making uniformly available medical care benefits to all recipients  
83.3 of public assistance, at such times as the federal government increases its participation in  
83.4 assistance expenditures for medical care to recipients of public assistance, the cost thereof  
83.5 to be borne in the same proportion as are grants of aid to said recipients.

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

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

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

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

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

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

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

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

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

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

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

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

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

84.29 (o) Have the authority to establish and enforce the following county reporting  
84.30 requirements:

84.31 (1) the commissioner shall establish fiscal and statistical reporting requirements necessary  
84.32 to account for the expenditure of funds allocated to counties for human services programs.  
84.33 When establishing financial and statistical reporting requirements, the commissioner shall

85.1 evaluate all reports, in consultation with the counties, to determine if the reports can be  
85.2 simplified or the number of reports can be reduced;

85.3 (2) the county board shall submit monthly or quarterly reports to the department as  
85.4 required by the commissioner. Monthly reports are due no later than 15 working days after  
85.5 the end of the month. Quarterly reports are due no later than 30 calendar days after the end  
85.6 of the quarter, unless the commissioner determines that the deadline must be shortened to  
85.7 20 calendar days to avoid jeopardizing compliance with federal deadlines or risking a loss  
85.8 of federal funding. Only reports that are complete, legible, and in the required format shall  
85.9 be accepted by the commissioner;

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

85.16 (4) a county board that submits reports that are late, illegible, incomplete, or not in the  
85.17 required format for two out of three consecutive reporting periods is considered  
85.18 noncompliant. When a county board is found to be noncompliant, the commissioner shall  
85.19 notify the county board of the reason the county board is considered noncompliant and  
85.20 request that the county board develop a corrective action plan stating how the county board  
85.21 plans to correct the problem. The corrective action plan must be submitted to the  
85.22 commissioner within 45 days after the date the county board received notice of  
85.23 noncompliance;

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

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

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

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

86.7 (q) Be responsible for ensuring the detection, prevention, investigation, and resolution  
86.8 of fraudulent activities or behavior by applicants, recipients, and other participants in the  
86.9 human services programs administered by the department.

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

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

86.19 (t) Have the authority to administer a supplemental drug rebate program for drugs  
86.20 purchased under the medical assistance program. The commissioner may enter into  
86.21 supplemental rebate contracts with pharmaceutical manufacturers and may require prior  
86.22 authorization for drugs that are from manufacturers that have not signed a supplemental  
86.23 rebate contract. Prior authorization of drugs shall be subject to the provisions of section  
86.24 256B.0625, subdivision 13.

86.25 (u) Operate the department's communication systems account established in Laws 1993,  
86.26 First Special Session chapter 1, article 1, section 2, subdivision 2, to manage shared  
86.27 communication costs necessary for the operation of the programs the commissioner  
86.28 supervises. Each account must be used to manage shared communication costs necessary  
86.29 for the operations of the programs the commissioner supervises. The commissioner may  
86.30 distribute the costs of operating and maintaining communication systems to participants in  
86.31 a manner that reflects actual usage. Costs may include acquisition, licensing, insurance,  
86.32 maintenance, repair, staff time and other costs as determined by the commissioner. Nonprofit  
86.33 organizations and state, county, and local government agencies involved in the operation  
86.34 of programs the commissioner supervises may participate in the use of the department's

87.1 communications technology and share in the cost of operation. The commissioner may  
87.2 accept on behalf of the state any gift, bequest, devise or personal property of any kind, or  
87.3 money tendered to the state for any lawful purpose pertaining to the communication activities  
87.4 of the department. Any money received for this purpose must be deposited in the department's  
87.5 communication systems accounts. Money collected by the commissioner for the use of  
87.6 communication systems must be deposited in the state communication systems account and  
87.7 is appropriated to the commissioner for purposes of this section.

87.8 (v) Receive any federal matching money that is made available through the medical  
87.9 assistance program for the consumer satisfaction survey. Any federal money received for  
87.10 the survey is appropriated to the commissioner for this purpose. The commissioner may  
87.11 expend the federal money received for the consumer satisfaction survey in either year of  
87.12 the biennium.

87.13 (w) Designate community information and referral call centers and incorporate cost  
87.14 reimbursement claims from the designated community information and referral call centers  
87.15 into the federal cost reimbursement claiming processes of the department according to  
87.16 federal law, rule, and regulations. Existing information and referral centers provided by  
87.17 Greater Twin Cities United Way or existing call centers for which Greater Twin Cities  
87.18 United Way has legal authority to represent, shall be included in these designations upon  
87.19 review by the commissioner and assurance that these services are accredited and in  
87.20 compliance with national standards. Any reimbursement is appropriated to the commissioner  
87.21 and all designated information and referral centers shall receive payments according to  
87.22 normal department schedules established by the commissioner upon final approval of  
87.23 allocation methodologies from the United States Department of Health and Human Services  
87.24 Division of Cost Allocation or other appropriate authorities.

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

87.28 (y) Authorize the method of payment to or from the department as part of the human  
87.29 services programs administered by the department. This authorization includes the receipt  
87.30 or disbursement of funds held by the department in a fiduciary capacity as part of the human  
87.31 services programs administered by the department.

87.32 (z) Designate the agencies that operate the Senior LinkAge Line under section 256.975,  
87.33 subdivision 7, and the Disability Hub under subdivision 24 as the state of Minnesota Aging  
87.34 and Disability Resource Center under United States Code, title 42, section 3001, the Older

88.1 Americans Act Amendments of 2006, and incorporate cost reimbursement claims from the  
88.2 designated centers into the federal cost reimbursement claiming processes of the department  
88.3 according to federal law, rule, and regulations. Any reimbursement must be appropriated  
88.4 to the commissioner and treated consistent with section 256.011. All Aging and Disability  
88.5 Resource Center designated agencies shall receive payments of grant funding that supports  
88.6 the activity and generates the federal financial participation according to Board on Aging  
88.7 administrative granting mechanisms.

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

88.9 Sec. 57. Minnesota Statutes 2024, section 256.01, subdivision 5, is amended to read:

88.10 Subd. 5. **Gifts, contributions, pensions and benefits; acceptance.** The commissioner  
88.11 may receive and accept on behalf of patients ~~and residents at the several state hospitals for~~  
88.12 ~~persons with mental illness or developmental disabilities during the period of their~~  
88.13 ~~hospitalization and while on provisional discharge therefrom,~~ money due and payable to  
88.14 them as old age and survivors insurance benefits, veterans benefits, pensions or other such  
88.15 monetary benefits. Such gifts, contributions, pensions and benefits shall be deposited in and  
88.16 disbursed from the social welfare fund provided for in sections 256.88 to 256.92.

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

88.18 Sec. 58. Minnesota Statutes 2024, section 256.019, subdivision 1, is amended to read:

88.19 Subdivision 1. **Retention rates.** When an assistance recovery amount is collected and  
88.20 posted by a county agency under the provisions governing public assistance programs  
88.21 including general assistance medical care formerly codified in chapter 256D, general  
88.22 assistance, and Minnesota supplemental aid, the county may keep one-half of the recovery  
88.23 made by the county agency using any method other than recoupment. For medical assistance,  
88.24 if the recovery is made by a county agency using any method other than recoupment, the  
88.25 county may keep one-half of the nonfederal share of the recovery. For MinnesotaCare, if  
88.26 the recovery is collected and posted by the county agency, the county may keep one-half  
88.27 of the nonfederal share of the recovery.

88.28 This does not apply to recoveries from medical providers or to recoveries begun by the  
88.29 Department of Human Services' Surveillance and Utilization Review Division, ~~State Hospital~~  
88.30 ~~Collections Unit,~~ and the Benefit Recoveries Division ~~or,~~ by the Direct Care and Treatment  
88.31 State Hospital Collections Unit, the attorney general's office, or child support collections.

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

89.1 Sec. 59. Minnesota Statutes 2024, section 256.0281, is amended to read:

89.2 **256.0281 INTERAGENCY DATA EXCHANGE.**

89.3 (a) The Department of Human Services, the Department of Health, Direct Care and  
89.4 Treatment, and the Office of the Ombudsman for Mental Health and Developmental  
89.5 Disabilities may establish interagency agreements governing the electronic exchange of  
89.6 data on providers and individuals collected, maintained, or used by each agency when such  
89.7 exchange is outlined by each agency in an interagency agreement to accomplish the purposes  
89.8 in clauses (1) to (4):

89.9 (1) to improve provider enrollment processes for home and community-based services  
89.10 and state plan home care services;

89.11 (2) to improve quality management of providers between state agencies;

89.12 (3) to establish and maintain provider eligibility to participate as providers under  
89.13 Minnesota health care programs; or

89.14 (4) to meet the quality assurance reporting requirements under federal law under section  
89.15 1915(c) of the Social Security Act related to home and community-based waiver programs.

89.16 (b) Each interagency agreement must include provisions to ensure anonymity of  
89.17 individuals, including mandated reporters, and must outline the specific uses of and access  
89.18 to shared data within each agency. Electronic interfaces between source data systems  
89.19 developed under these interagency agreements must incorporate these provisions as well  
89.20 as other HIPAA provisions related to individual data.

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

89.22 Sec. 60. Minnesota Statutes 2024, section 256.0451, subdivision 1, is amended to read:

89.23 Subdivision 1. **Scope.** (a) The requirements in this section apply to all fair hearings and  
89.24 appeals under sections 142A.20, subdivision 2, and 256.045, subdivision 3, paragraph (a),  
89.25 clauses (1), (2), (3), (5), (6), (7), (10), and (12). Except as provided in subdivisions 3 and  
89.26 19, the requirements under this section apply to fair hearings and appeals under section  
89.27 256.045, subdivision 3, paragraph (a), clauses (4), (8), (9), and (11).

89.28 (b) For purposes of this section, "person" means an individual who, on behalf of  
89.29 themselves or their household, is appealing or disputing or challenging an action, a decision,  
89.30 or a failure to act, by an agency ~~in the human services system~~ subject to this section. When  
89.31 a person involved in a proceeding under this section is represented by an attorney or by an  
89.32 authorized representative, the term "person" also means the person's attorney or authorized

90.1 representative. Any notice sent to the person involved in the hearing must also be sent to  
90.2 the person's attorney or authorized representative.

90.3 (c) For purposes of this section, "agency" means ~~the~~ a county human services agency,  
90.4 ~~the~~ a state ~~human services~~ agency, and, where applicable, any entity involved under a  
90.5 contract, subcontract, grant, or subgrant with the state agency or with a county agency, that  
90.6 provides or operates programs or services in which appeals are governed by section 256.045.

90.7 (d) For purposes of this section, "state agency" means the Department of Human Services;  
90.8 the Department of Health; the Department of Education; the Department of Children, Youth,  
90.9 and Families; or Direct Care and Treatment.

90.10 Sec. 61. Minnesota Statutes 2024, section 256.0451, subdivision 3, is amended to read:

90.11 Subd. 3. **Agency appeal summary.** (a) Except in fair hearings and appeals under section  
90.12 256.045, subdivision 3, paragraph (a), clauses (4), (9), and (10), the agency involved in an  
90.13 appeal must prepare a state agency appeal summary for each fair hearing appeal. The state  
90.14 agency appeal summary shall be mailed or otherwise delivered to the person who is involved  
90.15 in the appeal at least three working days before the date of the hearing. The state agency  
90.16 appeal summary must also be mailed or otherwise delivered to the ~~department's~~ Department  
90.17 of Human Services' Appeals Office at least three working days before the date of the fair  
90.18 hearing appeal.

90.19 (b) In addition, the human services judge shall confirm that the state agency appeal  
90.20 summary is mailed or otherwise delivered to the person involved in the appeal as required  
90.21 under paragraph (a). The person involved in the fair hearing should be provided, through  
90.22 the state agency appeal summary or other reasonable methods, appropriate information  
90.23 about the procedures for the fair hearing and an adequate opportunity to prepare. These  
90.24 requirements apply equally to the state agency or an entity under contract when involved  
90.25 in the appeal.

90.26 (c) The contents of the state agency appeal summary must be adequate to inform the  
90.27 person involved in the appeal of the evidence on which the agency relies and the legal basis  
90.28 for the agency's action or determination.

90.29 Sec. 62. Minnesota Statutes 2024, section 256.0451, subdivision 6, is amended to read:

90.30 Subd. 6. **Appeal request for emergency assistance or urgent matter.** (a) When an  
90.31 appeal involves an application for emergency assistance, the agency involved shall mail or  
90.32 otherwise deliver the state agency appeal summary to the ~~department's~~ Department of Human

91.1 Services' Appeals Office within two working days of receiving the request for an appeal.

91.2 A person may also request that a fair hearing be held on an emergency basis when the issue  
91.3 requires an immediate resolution. The human services judge shall schedule the fair hearing  
91.4 on the earliest available date according to the urgency of the issue involved. Issuance of the  
91.5 recommended decision after an emergency hearing shall be expedited.

91.6 (b) The applicable commissioner or executive board shall issue a written decision within  
91.7 five working days of receiving the recommended decision, shall immediately inform the  
91.8 parties of the outcome by telephone, and shall mail the decision no later than two working  
91.9 days following the date of the decision.

91.10 Sec. 63. Minnesota Statutes 2024, section 256.0451, subdivision 8, is amended to read:

91.11 Subd. 8. **Subpoenas.** A person involved in a fair hearing or the agency may request a  
91.12 subpoena for a witness, for evidence, or for both. A reasonable number of subpoenas shall  
91.13 be issued to require the attendance and the testimony of witnesses, and the production of  
91.14 evidence relating to any issue of fact in the appeal hearing. The request for a subpoena must  
91.15 show a need for the subpoena and the general relevance to the issues involved. The subpoena  
91.16 shall be issued in the name of the Department of Human Services and shall be served and  
91.17 enforced as provided in section 357.22 and the Minnesota Rules of Civil Procedure.

91.18 An individual or entity served with a subpoena may petition the human services judge  
91.19 in writing to vacate or modify a subpoena. The human services judge shall resolve such a  
91.20 petition in a prehearing conference involving all parties and shall make a written decision.  
91.21 A subpoena may be vacated or modified if the human services judge determines that the  
91.22 testimony or evidence sought does not relate with reasonable directness to the issues of the  
91.23 fair hearing appeal; that the subpoena is unreasonable, over broad, or oppressive; that the  
91.24 evidence sought is repetitious or cumulative; or that the subpoena has not been served  
91.25 reasonably in advance of the time when the appeal hearing will be held.

91.26 Sec. 64. Minnesota Statutes 2024, section 256.0451, subdivision 9, is amended to read:

91.27 Subd. 9. **No ex parte contact.** The human services judge shall not have ex parte contact  
91.28 on substantive issues with the agency or with any person or witness in a fair hearing appeal.  
91.29 No employee of ~~the Department or an~~ agency shall review, interfere with, change, or attempt  
91.30 to influence the recommended decision of the human services judge in any fair hearing  
91.31 appeal, except through the procedure allowed in subdivision 18. The limitations in this  
91.32 subdivision do not affect the applicable commissioner's or executive board's authority to  
91.33 review or reconsider decisions or make final decisions.

92.1 Sec. 65. Minnesota Statutes 2024, section 256.0451, subdivision 18, is amended to read:

92.2 Subd. 18. **Inviting comment by ~~department~~ state agency.** The human services judge  
92.3 or the applicable commissioner or executive board may determine that a written comment  
92.4 by the ~~department~~ state agency about the policy implications of a specific legal issue could  
92.5 help resolve a pending appeal. Such a written policy comment from the ~~department~~ state  
92.6 agency shall be obtained only by a written request that is also sent to the person involved  
92.7 and to the agency or its representative. When such a written comment is received, both the  
92.8 person involved in the hearing and the agency shall have adequate opportunity to review,  
92.9 evaluate, and respond to the written comment, including submission of additional testimony  
92.10 or evidence, and cross-examination concerning the written comment.

92.11 Sec. 66. Minnesota Statutes 2024, section 256.0451, subdivision 22, is amended to read:

92.12 Subd. 22. **Decisions.** A timely, written decision must be issued in every appeal. Each  
92.13 decision must contain a clear ruling on the issues presented in the appeal hearing and should  
92.14 contain a ruling only on questions directly presented by the appeal and the arguments raised  
92.15 in the appeal.

92.16 (a) A written decision must be issued within 90 days of the date the person involved  
92.17 requested the appeal unless a shorter time is required by law. An additional 30 days is  
92.18 provided in those cases where the applicable commissioner or executive board refuses to  
92.19 accept the recommended decision. In appeals of maltreatment determinations or  
92.20 disqualifications filed pursuant to section 256.045, subdivision 3, paragraph (a), clause (4),  
92.21 (8), or (9), that also give rise to possible licensing actions, the 90-day period for issuing  
92.22 final decisions does not begin until the later of the date that the licensing authority provides  
92.23 notice to the appeals division that the authority has made the final determination in the  
92.24 matter or the date the appellant files the last appeal in the consolidated matters.

92.25 (b) The decision must contain both findings of fact and conclusions of law, clearly  
92.26 separated and identified. The findings of fact must be based on the entire record. Each  
92.27 finding of fact made by the human services judge shall be supported by a preponderance  
92.28 of the evidence unless a different standard is required under the regulations of a particular  
92.29 program. The "preponderance of the evidence" means, in light of the record as a whole, the  
92.30 evidence leads the human services judge to believe that the finding of fact is more likely to  
92.31 be true than not true. The legal claims or arguments of a participant do not constitute either  
92.32 a finding of fact or a conclusion of law, except to the extent the human services judge adopts  
92.33 an argument as a finding of fact or conclusion of law.

92.34 The decision shall contain at least the following:

93.1 (1) a listing of the date and place of the hearing and the participants at the hearing;

93.2 (2) a clear and precise statement of the issues, including the dispute under consideration  
93.3 and the specific points which must be resolved in order to decide the case;

93.4 (3) a listing of the material, including exhibits, records, reports, placed into evidence at  
93.5 the hearing, and upon which the hearing decision is based;

93.6 (4) the findings of fact based upon the entire hearing record. The findings of fact must  
93.7 be adequate to inform the participants and any interested person in the public of the basis  
93.8 of the decision. If the evidence is in conflict on an issue which must be resolved, the findings  
93.9 of fact must state the reasoning used in resolving the conflict;

93.10 (5) conclusions of law that address the legal authority for the hearing and the ruling, and  
93.11 which give appropriate attention to the claims of the participants to the hearing;

93.12 (6) a clear and precise statement of the decision made resolving the dispute under  
93.13 consideration in the hearing; and

93.14 (7) written notice of the right to appeal to district court or to request reconsideration,  
93.15 and of the actions required and the time limits for taking appropriate action to appeal to  
93.16 district court or to request a reconsideration.

93.17 (c) The human services judge shall not independently investigate facts or otherwise rely  
93.18 on information not presented at the hearing. The human services judge may not contact  
93.19 other agency personnel, except as provided in subdivision 18. The human services judge's  
93.20 recommended decision must be based exclusively on the testimony and evidence presented  
93.21 at the hearing, and legal arguments presented, and the human services judge's research and  
93.22 knowledge of the law.

93.23 (d) The applicable commissioner ~~will~~ or executive board must review the recommended  
93.24 decision and accept or refuse to accept the decision according to section 142A.20, subdivision  
93.25 3, or 256.045, subdivision 5 or 5a.

93.26 Sec. 67. Minnesota Statutes 2024, section 256.0451, subdivision 23, is amended to read:

93.27 Subd. 23. **Refusal to accept recommended orders.** (a) If the applicable commissioner  
93.28 or executive board refuses to accept the recommended order from the human services judge,  
93.29 the person involved, the person's attorney or authorized representative, and the agency shall  
93.30 be sent a copy of the recommended order, a detailed explanation of the basis for refusing  
93.31 to accept the recommended order, and the proposed modified order.

94.1 (b) The person involved and the agency shall have at least ten business days to respond  
94.2 to the proposed modification of the recommended order. The person involved and the agency  
94.3 may submit a legal argument concerning the proposed modification, and may propose to  
94.4 submit additional evidence that relates to the proposed modified order.

94.5 Sec. 68. Minnesota Statutes 2024, section 256.0451, subdivision 24, is amended to read:

94.6 Subd. 24. **Reconsideration.** (a) Reconsideration may be requested within 30 days of  
94.7 the date of the applicable commissioner's or executive board's final order. If reconsideration  
94.8 is requested under section 142A.20, subdivision 3, or 256.045, subdivision 5 or 5a, the other  
94.9 participants in the appeal shall be informed of the request. The person seeking reconsideration  
94.10 has the burden to demonstrate why the matter should be reconsidered. The request for  
94.11 reconsideration may include legal argument and may include proposed additional evidence  
94.12 supporting the request. The other participants shall be sent a copy of all material submitted  
94.13 in support of the request for reconsideration and must be given ten days to respond.

94.14 (b) When the requesting party raises a question as to the appropriateness of the findings  
94.15 of fact, the applicable commissioner or executive board shall review the entire record.

94.16 (c) When the requesting party questions the appropriateness of a conclusion of law, the  
94.17 applicable commissioner or executive board shall consider the recommended decision, the  
94.18 decision under reconsideration, and the material submitted in connection with the  
94.19 reconsideration. The applicable commissioner or executive board shall review the remaining  
94.20 record as necessary to issue a reconsidered decision.

94.21 (d) The applicable commissioner or executive board shall issue a written decision on  
94.22 reconsideration in a timely fashion. The decision must clearly inform the parties that this  
94.23 constitutes the final administrative decision, advise the participants of the right to seek  
94.24 judicial review, and the deadline for doing so.

94.25 Sec. 69. Minnesota Statutes 2024, section 256.4825, is amended to read:

94.26 **256.4825 REPORT REGARDING PROGRAMS AND SERVICES FOR PEOPLE**  
94.27 **WITH DISABILITIES.**

94.28 The Minnesota State Council on Disability, the Minnesota Consortium for Citizens with  
94.29 Disabilities, and the Arc of Minnesota may submit an annual report by January 15 of each  
94.30 year, beginning in 2012, to the chairs and ranking minority members of the legislative  
94.31 committees with jurisdiction over programs serving people with disabilities as provided in  
94.32 this section. The report must describe the existing state policies and goals for programs

95.1 serving people with disabilities including, but not limited to, programs for employment,  
 95.2 transportation, housing, education, quality assurance, consumer direction, physical and  
 95.3 programmatic access, and health. The report must provide data and measurements to assess  
 95.4 the extent to which the policies and goals are being met. The commissioner of human  
 95.5 services, the Direct Care and Treatment executive board, and the commissioners of other  
 95.6 state agencies administering programs for people with disabilities shall cooperate with the  
 95.7 Minnesota State Council on Disability, the Minnesota Consortium for Citizens with  
 95.8 Disabilities, and the Arc of Minnesota and provide those organizations with existing  
 95.9 published information and reports that will assist in the preparation of the report.

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

95.11 Sec. 70. Minnesota Statutes 2024, section 256.93, subdivision 1, is amended to read:

95.12 Subdivision 1. **Limitations.** In any case where the guardianship of any child with a  
 95.13 developmental disability or who is disabled, dependent, neglected or delinquent, or a child  
 95.14 born to a mother who was not married to the child's father when the child was conceived  
 95.15 nor when the child was born, has been ~~committed~~ appointed to the commissioner of human  
 95.16 services, and in any case where the guardianship of any person with a developmental  
 95.17 disability has been ~~committed~~ appointed to the commissioner of human services, the court  
 95.18 having jurisdiction of the estate may on such notice as the court may direct, authorize the  
 95.19 commissioner to take possession of the personal property in the estate, liquidate it, and hold  
 95.20 the proceeds in trust for the ward, to be invested, expended and accounted for as provided  
 95.21 by sections 256.88 to 256.92.

95.22 Sec. 71. Minnesota Statutes 2024, section 256.98, subdivision 7, is amended to read:

95.23 Subd. 7. **Division of recovered amounts.** Except for recoveries under chapter 142E, if  
 95.24 the state is responsible for the recovery, the amounts recovered shall be paid to the appropriate  
 95.25 units of government. If the recovery is directly attributable to a county, the county may  
 95.26 retain one-half of the nonfederal share of any recovery from a recipient or the recipient's  
 95.27 estate.

95.28 This subdivision does not apply to recoveries from medical providers or to recoveries  
 95.29 involving the Department of Human ~~services~~, Services' Surveillance and Utilization Review  
 95.30 Division, ~~state hospital collections unit~~, and the Benefit Recoveries Division or the Direct  
 95.31 Care and Treatment State Hospital Collections Unit.

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

96.1 Sec. 72. Minnesota Statutes 2024, section 256B.092, subdivision 10, is amended to read:

96.2 Subd. 10. **Admission of persons to and discharge of persons from regional treatment**  
96.3 **centers.** (a) Prior to the admission of a person to a regional treatment center program for  
96.4 persons with developmental disabilities, the case manager shall make efforts to secure  
96.5 community-based alternatives. If these alternatives are rejected by the person, the person's  
96.6 legal guardian or conservator, or the county agency in favor of a regional treatment center  
96.7 placement, the case manager shall document the reasons why the alternatives were rejected.

96.8 (b) Assessment and support planning must be completed in accordance with requirements  
96.9 identified in section 256B.0911.

96.10 (c) No discharge shall take place until disputes are resolved under section 256.045,  
96.11 subdivision 4a, or until a review by the ~~commissioner~~ Direct Care and Treatment executive  
96.12 board is completed upon request of the chief executive officer or program director of the  
96.13 regional treatment center, or the county agency. For persons under public guardianship, the  
96.14 ombudsman may request a review or hearing under section 256.045.

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

96.16 Sec. 73. Minnesota Statutes 2024, section 256G.09, subdivision 4, is amended to read:

96.17 Subd. 4. **Appeals.** A local agency that is aggrieved by the order of ~~the~~ a department or  
96.18 the executive board may appeal the opinion to the district court of the county responsible  
96.19 for furnishing assistance or services by serving a written copy of a notice of appeal on ~~the~~  
96.20 a commissioner or the executive board and any adverse party of record within 30 days after  
96.21 the date the department issued the opinion, and by filing the original notice and proof of  
96.22 service with the court administrator of district court. Service may be made personally or by  
96.23 mail. Service by mail is complete upon mailing.

96.24 ~~The~~ A commissioner or the executive board may elect to become a party to the  
96.25 proceedings in district court. The court may consider the matter in or out of chambers and  
96.26 shall take no new or additional evidence.

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

96.28 Sec. 74. Minnesota Statutes 2024, section 256G.09, subdivision 5, is amended to read:

96.29 Subd. 5. **Payment pending appeal.** After ~~the~~ a department or the executive board issues  
96.30 an opinion in any submission under this section, the service or assistance covered by the  
96.31 submission must be provided or paid pending or during an appeal to the district court.

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

97.2 Sec. 75. Minnesota Statutes 2024, section 299F.77, subdivision 2, is amended to read:

97.3 Subd. 2. **Background check.** (a) For licenses issued by the commissioner under section  
97.4 299F.73, the applicant for licensure must provide the commissioner with all of the  
97.5 information required by Code of Federal Regulations, title 28, section 25.7. The commissioner  
97.6 shall forward the information to the superintendent of the Bureau of Criminal Apprehension  
97.7 so that criminal records, histories, and warrant information on the applicant can be retrieved  
97.8 from the Minnesota Crime Information System and the National Instant Criminal Background  
97.9 Check System, as well as the civil commitment records maintained by ~~the Department of~~  
97.10 ~~Human Services~~ Direct Care and Treatment. The results must be returned to the commissioner  
97.11 to determine if the individual applicant is qualified to receive a license.

97.12 (b) For permits issued by a county sheriff or chief of police under section 299F.75, the  
97.13 applicant for a permit must provide the county sheriff or chief of police with all of the  
97.14 information required by Code of Federal Regulations, title 28, section 25.7. The county  
97.15 sheriff or chief of police must check, by means of electronic data transfer, criminal records,  
97.16 histories, and warrant information on each applicant through the Minnesota Crime  
97.17 Information System and the National Instant Criminal Background Check System, as well  
97.18 as the civil commitment records maintained by ~~the Department of Human Services~~ Direct  
97.19 Care and Treatment. The county sheriff or chief of police shall use the results of the query  
97.20 to determine if the individual applicant is qualified to receive a permit.

97.21 Sec. 76. Minnesota Statutes 2024, section 342.04, is amended to read:

97.22 **342.04 STUDIES; REPORTS.**

97.23 (a) The office shall conduct a study to determine the expected size and growth of the  
97.24 regulated cannabis industry and hemp consumer industry, including an estimate of the  
97.25 demand for cannabis flower and cannabis products, the number and geographic distribution  
97.26 of cannabis businesses needed to meet that demand, and the anticipated business from  
97.27 residents of other states.

97.28 (b) The office shall conduct a study to determine the size of the illicit cannabis market,  
97.29 the sources of illicit cannabis flower and illicit cannabis products in the state, the locations  
97.30 of citations issued and arrests made for cannabis offenses, and the subareas, such as census  
97.31 tracts or neighborhoods, that experience a disproportionately large amount of cannabis  
97.32 enforcement.

98.1 (c) The office shall conduct a study on impaired driving to determine:

98.2 (1) the number of accidents involving one or more drivers who admitted to using cannabis  
98.3 flower, cannabis products, lower-potency hemp edibles, or hemp-derived consumer products,  
98.4 or who tested positive for cannabis or tetrahydrocannabinol;

98.5 (2) the number of arrests of individuals for impaired driving in which the individual  
98.6 tested positive for cannabis or tetrahydrocannabinol; and

98.7 (3) the number of convictions for driving under the influence of cannabis flower, cannabis  
98.8 products, lower-potency hemp edibles, hemp-derived consumer products, or  
98.9 tetrahydrocannabinol.

98.10 (d) The office shall provide preliminary reports on the studies conducted pursuant to  
98.11 paragraphs (a) to (c) to the legislature by January 15, 2024, and shall provide final reports  
98.12 to the legislature by January 15, 2025. The reports may be consolidated into a single report  
98.13 by the office.

98.14 (e) The office shall collect existing data from the Department of Human Services,  
98.15 Department of Health, Direct Care and Treatment, Minnesota state courts, and hospitals  
98.16 licensed under chapter 144 on the utilization of mental health and substance use disorder  
98.17 services, emergency room visits, and commitments to identify any increase in the services  
98.18 provided or any increase in the number of visits or commitments. The office shall also obtain  
98.19 summary data from existing first episode psychosis programs on the number of persons  
98.20 served by the programs and number of persons on the waiting list. All information collected  
98.21 by the office under this paragraph shall be included in the report required under paragraph  
98.22 (f).

98.23 (f) The office shall conduct an annual market analysis on the status of the regulated  
98.24 cannabis industry and submit a report of the findings. The office shall submit the report by  
98.25 January 15, 2025, and each January 15 thereafter and the report may be combined with the  
98.26 annual report submitted by the office. The process of completing the market analysis must  
98.27 include holding public meetings to solicit the input of consumers, market stakeholders, and  
98.28 potential new applicants and must include an assessment as to whether the office has issued  
98.29 the necessary number of licenses in order to:

98.30 (1) ensure the sufficient supply of cannabis flower and cannabis products to meet demand;

98.31 (2) provide market stability;

98.32 (3) ensure a competitive market; and

98.33 (4) limit the sale of unregulated cannabis flower and cannabis products.

99.1 (g) The office shall submit an annual report to the legislature by January 15, 2024, and  
99.2 each January 15 thereafter. The annual report shall include but not be limited to the following:

99.3 (1) the status of the regulated cannabis industry;

99.4 (2) the status of the illicit cannabis market and hemp consumer industry;

99.5 (3) the number of accidents, arrests, and convictions involving drivers who admitted to  
99.6 using cannabis flower, cannabis products, lower-potency hemp edibles, or hemp-derived  
99.7 consumer products or who tested positive for cannabis or tetrahydrocannabinol;

99.8 (4) the change in potency, if any, of cannabis flower and cannabis products available  
99.9 through the regulated market;

99.10 (5) progress on providing opportunities to individuals and communities that experienced  
99.11 a disproportionate, negative impact from cannabis prohibition, including but not limited to  
99.12 providing relief from criminal convictions and increasing economic opportunities;

99.13 (6) the status of racial and geographic diversity in the cannabis industry;

99.14 (7) proposed legislative changes, including but not limited to recommendations to  
99.15 streamline licensing systems and related administrative processes;

99.16 (8) information on the adverse effects of second-hand smoke from any cannabis flower,  
99.17 cannabis products, and hemp-derived consumer products that are consumed by the  
99.18 combustion or vaporization of the product and the inhalation of smoke, aerosol, or vapor  
99.19 from the product; and

99.20 (9) recommendations for the levels of funding for:

99.21 (i) a coordinated education program to address and raise public awareness about the top  
99.22 three adverse health effects, as determined by the commissioner of health, associated with  
99.23 the use of cannabis flower, cannabis products, lower-potency hemp edibles, or hemp-derived  
99.24 consumer products by individuals under 21 years of age;

99.25 (ii) a coordinated education program to educate pregnant individuals, breastfeeding  
99.26 individuals, and individuals who may become pregnant on the adverse health effects of  
99.27 cannabis flower, cannabis products, lower-potency hemp edibles, and hemp-derived consumer  
99.28 products;

99.29 (iii) training, technical assistance, and educational materials for home visiting programs,  
99.30 Tribal home visiting programs, and child welfare workers regarding safe and unsafe use of  
99.31 cannabis flower, cannabis products, lower-potency hemp edibles, and hemp-derived consumer  
99.32 products in homes with infants and young children;

100.1 (iv) model programs to educate middle school and high school students on the health  
100.2 effects on children and adolescents of the use of cannabis flower, cannabis products,  
100.3 lower-potency hemp edibles, hemp-derived consumer products, and other intoxicating or  
100.4 controlled substances;

100.5 (v) grants issued through the CanTrain, CanNavigate, CanStartup, and CanGrow  
100.6 programs;

100.7 (vi) grants to organizations for community development in social equity communities  
100.8 through the CanRenew program;

100.9 (vii) training of peace officers and law enforcement agencies on changes to laws involving  
100.10 cannabis flower, cannabis products, lower-potency hemp edibles, and hemp-derived consumer  
100.11 products and the law's impact on searches and seizures;

100.12 (viii) training of peace officers to increase the number of drug recognition experts;

100.13 (ix) training of peace officers on the cultural uses of sage and distinguishing use of sage  
100.14 from the use of cannabis flower, including whether the Board of Peace Officer Standards  
100.15 and Training should approve or develop training materials;

100.16 (x) the retirement and replacement of drug detection canines; and

100.17 (xi) the Department of Human Services and county social service agencies to address  
100.18 any increase in demand for services.

100.19 (g) In developing the recommended funding levels under paragraph (f), clause (9), items  
100.20 (vii) to (xi), the office shall consult with local law enforcement agencies, the Minnesota  
100.21 Chiefs of Police Association, the Minnesota Sheriff's Association, the League of Minnesota  
100.22 Cities, the Association of Minnesota Counties, and county social services agencies.

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

100.24 Sec. 77. Minnesota Statutes 2024, section 352.91, subdivision 3f, is amended to read:

100.25 Subd. 3f. **Additional Direct Care and Treatment personnel.** (a) "Covered correctional  
100.26 service" means service by a state employee in one of the employment positions specified  
100.27 in paragraph (b) in the state-operated forensic services program or the Minnesota Sex  
100.28 Offender Program if at least 75 percent of the employee's working time is spent in direct  
100.29 contact with patients and the determination of this direct contact is certified to the executive  
100.30 director by the ~~commissioner of human services or~~ Direct Care and Treatment executive  
100.31 board.

100.32 (b) The employment positions are:

- 101.1 (1) baker;
- 101.2 (2) behavior analyst 2;
- 101.3 (3) behavior analyst 3;
- 101.4 (4) certified occupational therapy assistant 1;
- 101.5 (5) certified occupational therapy assistant 2;
- 101.6 (6) client advocate;
- 101.7 (7) clinical program therapist 2;
- 101.8 (8) clinical program therapist 3;
- 101.9 (9) clinical program therapist 4;
- 101.10 (10) cook;
- 101.11 (11) culinary supervisor;
- 101.12 (12) customer services specialist principal;
- 101.13 (13) dental assistant registered;
- 101.14 (14) dental hygienist;
- 101.15 (15) food service worker;
- 101.16 (16) food services supervisor;
- 101.17 (17) group supervisor;
- 101.18 (18) group supervisor assistant;
- 101.19 (19) human services support specialist;
- 101.20 (20) licensed alcohol and drug counselor;
- 101.21 (21) licensed practical nurse;
- 101.22 (22) management analyst 3;
- 101.23 (23) music therapist;
- 101.24 (24) occupational therapist;
- 101.25 (25) occupational therapist, senior;
- 101.26 (26) physical therapist;
- 101.27 (27) psychologist 1;

- 102.1 (28) psychologist 2;
- 102.2 (29) psychologist 3;
- 102.3 (30) recreation program assistant;
- 102.4 (31) recreation therapist lead;
- 102.5 (32) recreation therapist senior;
- 102.6 (33) rehabilitation counselor senior;
- 102.7 (34) residential program lead;
- 102.8 (35) security supervisor;
- 102.9 (36) skills development specialist;
- 102.10 (37) social worker senior;
- 102.11 (38) social worker specialist;
- 102.12 (39) social worker specialist, senior;
- 102.13 (40) special education program assistant;
- 102.14 (41) speech pathology clinician;
- 102.15 (42) substance use disorder counselor senior;
- 102.16 (43) work therapy assistant; and
- 102.17 (44) work therapy program coordinator.

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

102.19 Sec. 78. Minnesota Statutes 2024, section 401.17, subdivision 1, is amended to read:

102.20 Subdivision 1. **Establishment; members.** (a) The commissioner must establish a  
102.21 Community Supervision Advisory Committee to develop and make recommendations to  
102.22 the commissioner on standards for probation, supervised release, and community supervision.  
102.23 The committee consists of 19 members as follows:

102.24 (1) two directors appointed by the Minnesota Association of Community Corrections  
102.25 Act Counties;

102.26 (2) two probation directors appointed by the Minnesota Association of County Probation  
102.27 Officers;

103.1 (3) three county commissioner representatives appointed by the Association of Minnesota  
103.2 Counties;

103.3 (4) two behavioral health, treatment, or programming providers who work directly with  
103.4 individuals on correctional supervision, one appointed by the ~~Department of Human Services~~  
103.5 Department of Corrections and one appointed by the Minnesota Association of County  
103.6 Social Service Administrators;

103.7 (5) two representatives appointed by the Minnesota Indian Affairs Council;

103.8 (6) two commissioner-appointed representatives from the Department of Corrections;

103.9 (7) the chair of the statewide Evidence-Based Practice Advisory Committee;

103.10 (8) three individuals who have been supervised, either individually or collectively, under  
103.11 each of the state's three community supervision delivery systems appointed by the  
103.12 commissioner in consultation with the Minnesota Association of County Probation Officers  
103.13 and the Minnesota Association of Community Corrections Act Counties;

103.14 (9) an advocate for victims of crime appointed by the commissioner; and

103.15 (10) a representative from a community-based research and advocacy entity appointed  
103.16 by the commissioner.

103.17 (b) When an appointing authority selects an individual for membership on the committee,  
103.18 the authority must make reasonable efforts to reflect geographic diversity and to appoint  
103.19 qualified members of protected groups, as defined under section 43A.02, subdivision 33.

103.20 (c) Chapter 15 applies to the extent consistent with this section.

103.21 (d) The commissioner must convene the first meeting of the committee on or before  
103.22 October 1, 2023.

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

103.24 Sec. 79. Minnesota Statutes 2024, section 507.071, subdivision 1, is amended to read:

103.25 Subdivision 1. **Definitions.** For the purposes of this section the following terms have  
103.26 the meanings given:

103.27 (a) "Beneficiary" or "grantee beneficiary" means a person or entity named as a grantee  
103.28 beneficiary in a transfer on death deed, including a successor grantee beneficiary.

103.29 (b) "County agency" means the county department or office designated to recover medical  
103.30 assistance benefits from the estates of decedents.

104.1 (c) "Grantor owner" means an owner, whether individually, as a joint tenant, or as a  
104.2 tenant in common, named as a grantor in a transfer on death deed upon whose death the  
104.3 conveyance or transfer of the described real property is conditioned. Grantor owner does  
104.4 not include a spouse who joins in a transfer on death deed solely for the purpose of conveying  
104.5 or releasing statutory or other marital interests in the real property to be conveyed or  
104.6 transferred by the transfer on death deed.

104.7 (d) "Owner" means a person having an ownership or other interest in all or part of the  
104.8 real property to be conveyed or transferred by a transfer on death deed either at the time the  
104.9 deed is executed or at the time the transfer becomes effective. Owner does not include a  
104.10 spouse who joins in a transfer on death deed solely for the purpose of conveying or releasing  
104.11 statutory or other marital interests in the real property to be conveyed or transferred by the  
104.12 transfer on death deed.

104.13 (e) "Property" and "interest in real property" mean any interest in real property located  
104.14 in this state which is transferable on the death of the owner and includes, without limitation,  
104.15 an interest in real property defined in chapter 500, a mortgage, a deed of trust, a security  
104.16 interest in, or a security pledge of, an interest in real property, including the rights to  
104.17 payments of the indebtedness secured by the security instrument, a judgment, a tax lien,  
104.18 both the seller's and purchaser's interest in a contract for deed, land contract, purchase  
104.19 agreement, or earnest money contract for the sale and purchase of real property, including  
104.20 the rights to payments under such contracts, or any other lien on, or interest in, real property.

104.21 (f) "Recorded" means recorded in the office of the county recorder or registrar of titles,  
104.22 as appropriate for the real property described in the instrument to be recorded.

104.23 (g) "State agency" means the Department of Human Services or any successor agency  
104.24 or Direct Care and Treatment or any successor agency.

104.25 (h) "Transfer on death deed" means a deed authorized under this section.

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

104.27 Sec. 80. Minnesota Statutes 2024, section 611.57, subdivision 2, is amended to read:

104.28 Subd. 2. **Membership.** (a) The Certification Advisory Committee consists of the  
104.29 following members:

104.30 (1) a mental health professional, as defined in section 245I.02, subdivision 27, with  
104.31 community behavioral health experience, appointed by the governor;

105.1 (2) a board-certified forensic psychiatrist with experience in competency evaluations,  
105.2 providing competency attainment services, or both, appointed by the governor;

105.3 (3) a board-certified forensic psychologist with experience in competency evaluations,  
105.4 providing competency attainment services, or both, appointed by the governor;

105.5 (4) the president of the Minnesota Corrections Association or a designee;

105.6 (5) the Direct Care and Treatment ~~deputy commissioner~~ chief executive officer or a  
105.7 designee;

105.8 (6) the president of the Minnesota Association of County Social Service Administrators  
105.9 or a designee;

105.10 (7) the president of the Minnesota Association of Community Mental Health Providers  
105.11 or a designee;

105.12 (8) the president of the Minnesota Sheriffs' Association or a designee; and

105.13 (9) the executive director of the National Alliance on Mental Illness Minnesota or a  
105.14 designee.

105.15 (b) Members of the advisory committee serve without compensation and at the pleasure  
105.16 of the appointing authority. Vacancies shall be filled by the appointing authority consistent  
105.17 with the qualifications of the vacating member required by this subdivision.

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

105.19 Sec. 81. Minnesota Statutes 2024, section 611.57, subdivision 4, is amended to read:

105.20 Subd. 4. **Duties.** The Certification Advisory Committee shall consult with the Department  
105.21 of Human Services, the Department of Health, ~~and~~ the Department of Corrections, and  
105.22 Direct Care and Treatment; make recommendations to the Minnesota Competency Attainment  
105.23 Board regarding competency attainment curriculum, certification requirements for  
105.24 competency attainment programs including jail-based programs, and certification of  
105.25 individuals to provide competency attainment services; and provide information and  
105.26 recommendations on other issues relevant to competency attainment as requested by the  
105.27 board.

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

106.1 Sec. 82. Minnesota Statutes 2024, section 624.7131, subdivision 1, is amended to read:

106.2 Subdivision 1. **Information.** Any person may apply for a transferee permit by providing  
106.3 the following information in writing to the chief of police of an organized full time police  
106.4 department of the municipality in which the person resides or to the county sheriff if there  
106.5 is no such local chief of police:

106.6 (1) the name, residence, telephone number, and driver's license number or  
106.7 nonqualification certificate number, if any, of the proposed transferee;

106.8 (2) the sex, date of birth, height, weight, and color of eyes, and distinguishing physical  
106.9 characteristics, if any, of the proposed transferee;

106.10 (3) a statement that the proposed transferee authorizes the release to the local police  
106.11 authority of commitment information about the proposed transferee maintained by the  
106.12 ~~commissioner of human services~~ Direct Care and Treatment executive board, to the extent  
106.13 that the information relates to the proposed transferee's eligibility to possess a pistol or  
106.14 semiautomatic military-style assault weapon under section 624.713, subdivision 1; and

106.15 (4) a statement by the proposed transferee that the proposed transferee is not prohibited  
106.16 by section 624.713 from possessing a pistol or semiautomatic military-style assault weapon.

106.17 The statements shall be signed and dated by the person applying for a permit. At the  
106.18 time of application, the local police authority shall provide the applicant with a dated receipt  
106.19 for the application. The statement under clause (3) must comply with any applicable  
106.20 requirements of Code of Federal Regulations, title 42, sections 2.31 to 2.35, with respect  
106.21 to consent to disclosure of alcohol or drug abuse patient records.

106.22 Sec. 83. Minnesota Statutes 2024, section 624.7131, subdivision 2, is amended to read:

106.23 Subd. 2. **Investigation.** The chief of police or sheriff shall check criminal histories,  
106.24 records and warrant information relating to the applicant through the Minnesota Crime  
106.25 Information System, the national criminal record repository, and the National Instant Criminal  
106.26 Background Check System. The chief of police or sheriff shall also make a reasonable effort  
106.27 to check other available state and local record-keeping systems. The chief of police or sheriff  
106.28 shall obtain commitment information from the ~~commissioner of human services~~ Direct Care  
106.29 and Treatment executive board as provided in section 246C.15.

106.30 Sec. 84. Minnesota Statutes 2024, section 624.7132, subdivision 1, is amended to read:

106.31 Subdivision 1. **Required information.** Except as provided in this section and section  
106.32 624.7131, every person who agrees to transfer a pistol or semiautomatic military-style

107.1 assault weapon shall report the following information in writing to the chief of police of  
107.2 the organized full-time police department of the municipality where the proposed transferee  
107.3 resides or to the appropriate county sheriff if there is no such local chief of police:

107.4 (1) the name, residence, telephone number, and driver's license number or  
107.5 nonqualification certificate number, if any, of the proposed transferee;

107.6 (2) the sex, date of birth, height, weight, and color of eyes, and distinguishing physical  
107.7 characteristics, if any, of the proposed transferee;

107.8 (3) a statement that the proposed transferee authorizes the release to the local police  
107.9 authority of commitment information about the proposed transferee maintained by the  
107.10 ~~commissioner of human services~~ Direct Care and Treatment executive board, to the extent  
107.11 that the information relates to the proposed transferee's eligibility to possess a pistol or  
107.12 semiautomatic military-style assault weapon under section 624.713, subdivision 1;

107.13 (4) a statement by the proposed transferee that the transferee is not prohibited by section  
107.14 624.713 from possessing a pistol or semiautomatic military-style assault weapon; and

107.15 (5) the address of the place of business of the transferor.

107.16 The report shall be signed and dated by the transferor and the proposed transferee. The  
107.17 report shall be delivered by the transferor to the chief of police or sheriff no later than three  
107.18 days after the date of the agreement to transfer, excluding weekends and legal holidays.

107.19 The statement under clause (3) must comply with any applicable requirements of Code of  
107.20 Federal Regulations, title 42, sections 2.31 to 2.35, with respect to consent to disclosure of  
107.21 alcohol or drug abuse patient records.

107.22 Sec. 85. Minnesota Statutes 2024, section 624.7132, subdivision 2, is amended to read:

107.23 Subd. 2. **Investigation.** Upon receipt of a transfer report, the chief of police or sheriff  
107.24 shall check criminal histories, records and warrant information relating to the proposed  
107.25 transferee through the Minnesota Crime Information System, the national criminal record  
107.26 repository, and the National Instant Criminal Background Check System. The chief of police  
107.27 or sheriff shall also make a reasonable effort to check other available state and local  
107.28 record-keeping systems. The chief of police or sheriff shall obtain commitment information  
107.29 from the ~~commissioner of human services~~ Direct Care and Treatment executive board as  
107.30 provided in section 246C.15.

108.1 Sec. 86. Minnesota Statutes 2024, section 624.714, subdivision 3, is amended to read:

108.2 Subd. 3. **Form and contents of application.** (a) Applications for permits to carry must  
108.3 be an official, standardized application form, adopted under section 624.7151, and must set  
108.4 forth in writing only the following information:

108.5 (1) the applicant's name, residence, telephone number, if any, and driver's license number  
108.6 or state identification card number;

108.7 (2) the applicant's sex, date of birth, height, weight, and color of eyes and hair, and  
108.8 distinguishing physical characteristics, if any;

108.9 (3) the township or statutory city or home rule charter city, and county, of all Minnesota  
108.10 residences of the applicant in the last five years, though not including specific addresses;

108.11 (4) the township or city, county, and state of all non-Minnesota residences of the applicant  
108.12 in the last five years, though not including specific addresses;

108.13 (5) a statement that the applicant authorizes the release to the sheriff of commitment  
108.14 information about the applicant maintained by the ~~commissioner of human services~~ Direct  
108.15 Care and Treatment executive board or any similar agency or department of another state  
108.16 where the applicant has resided, to the extent that the information relates to the applicant's  
108.17 eligibility to possess a firearm; and

108.18 (6) a statement by the applicant that, to the best of the applicant's knowledge and belief,  
108.19 the applicant is not prohibited by law from possessing a firearm.

108.20 (b) The statement under paragraph (a), clause (5), must comply with any applicable  
108.21 requirements of Code of Federal Regulations, title 42, sections 2.31 to 2.35, with respect  
108.22 to consent to disclosure of alcohol or drug abuse patient records.

108.23 (c) An applicant must submit to the sheriff an application packet consisting only of the  
108.24 following items:

108.25 (1) a completed application form, signed and dated by the applicant;

108.26 (2) an accurate photocopy of the certificate described in subdivision 2a, paragraph (c),  
108.27 that is submitted as the applicant's evidence of training in the safe use of a pistol; and

108.28 (3) an accurate photocopy of the applicant's current driver's license, state identification  
108.29 card, or the photo page of the applicant's passport.

108.30 (d) In addition to the other application materials, a person who is otherwise ineligible  
108.31 for a permit due to a criminal conviction but who has obtained a pardon or expungement

109.1 setting aside the conviction, sealing the conviction, or otherwise restoring applicable rights,  
109.2 must submit a copy of the relevant order.

109.3 (e) Applications must be submitted in person.

109.4 (f) The sheriff may charge a new application processing fee in an amount not to exceed  
109.5 the actual and reasonable direct cost of processing the application or \$100, whichever is  
109.6 less. Of this amount, \$10 must be submitted to the commissioner and deposited into the  
109.7 general fund.

109.8 (g) This subdivision prescribes the complete and exclusive set of items an applicant is  
109.9 required to submit in order to apply for a new or renewal permit to carry. The applicant  
109.10 must not be asked or required to submit, voluntarily or involuntarily, any information, fees,  
109.11 or documentation beyond that specifically required by this subdivision. This paragraph does  
109.12 not apply to alternate training evidence accepted by the sheriff under subdivision 2a,  
109.13 paragraph (d).

109.14 (h) Forms for new and renewal applications must be available at all sheriffs' offices and  
109.15 the commissioner must make the forms available on the Internet.

109.16 (i) Application forms must clearly display a notice that a permit, if granted, is void and  
109.17 must be immediately returned to the sheriff if the permit holder is or becomes prohibited  
109.18 by law from possessing a firearm. The notice must list the applicable state criminal offenses  
109.19 and civil categories that prohibit a person from possessing a firearm.

109.20 (j) Upon receipt of an application packet and any required fee, the sheriff must provide  
109.21 a signed receipt indicating the date of submission.

109.22 Sec. 87. Minnesota Statutes 2024, section 624.714, subdivision 4, is amended to read:

109.23 Subd. 4. **Investigation.** (a) The sheriff must check, by means of electronic data transfer,  
109.24 criminal records, histories, and warrant information on each applicant through the Minnesota  
109.25 Crime Information System and the National Instant Criminal Background Check System.  
109.26 The sheriff shall also make a reasonable effort to check other available and relevant federal,  
109.27 state, or local record-keeping systems. The sheriff must obtain commitment information  
109.28 from the ~~commissioner of human services~~ Direct Care and Treatment executive board as  
109.29 provided in section 246C.15 or, if the information is reasonably available, as provided by  
109.30 a similar statute from another state.

109.31 (b) When an application for a permit is filed under this section, the sheriff must notify  
109.32 the chief of police, if any, of the municipality where the applicant resides. The police chief  
109.33 may provide the sheriff with any information relevant to the issuance of the permit.

110.1 (c) The sheriff must conduct a background check by means of electronic data transfer  
110.2 on a permit holder through the Minnesota Crime Information System and the National  
110.3 Instant Criminal Background Check System at least yearly to ensure continuing eligibility.  
110.4 The sheriff may also conduct additional background checks by means of electronic data  
110.5 transfer on a permit holder at any time during the period that a permit is in effect.

110.6 Sec. 88. Minnesota Statutes 2024, section 631.40, subdivision 3, is amended to read:

110.7 Subd. 3. **Departments of Human Services; Children, Youth, and Families; and**  
110.8 **Health licensees.** When a person who is affiliated with a program or facility ~~governed~~  
110.9 licensed by the Department of Human Services; Department of Children, Youth, and  
110.10 Families; or Department of Health is convicted of a disqualifying crime, the probation  
110.11 officer or corrections agent shall notify the commissioner of the conviction, as provided in  
110.12 chapter 245C.

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

110.14 Sec. 89. **REVISOR INSTRUCTION.**

110.15 (a) The revisor of statutes shall renumber Minnesota Statutes, section 252.50, subdivision  
110.16 5, as Minnesota Statutes, section 246C.11, subdivision 4a.

110.17 (b) The revisor of statutes shall renumber Minnesota Statutes, section 252.52, as  
110.18 Minnesota Statutes, section 246C.191.

110.19 (c) The revisor of statutes shall make necessary cross-reference changes consistent with  
110.20 the renumbering in this section.

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

110.22 Sec. 90. **REPEALER.**

110.23 (a) Minnesota Statutes 2024, sections 245.4862; 246.015, subdivision 3; 246.50,  
110.24 subdivision 2; and 246B.04, subdivision 1a, are repealed.

110.25 (b) Laws 2024, chapter 79, article 1, sections 15; 16; and 17, are repealed.

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

111.1 **ARTICLE 4**

111.2 **BEHAVIORAL HEALTH**

111.3 Section 1. Minnesota Statutes 2024, section 144.651, subdivision 2, is amended to read:

111.4 Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is  
 111.5 admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for  
 111.6 the purpose of diagnosis or treatment bearing on the physical or mental health of that person.  
 111.7 For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a  
 111.8 person who receives health care services at an outpatient surgical center or at a birth center  
 111.9 licensed under section 144.615. "Patient" also means a minor who is admitted to a residential  
 111.10 program as defined in section 253C.01. For purposes of subdivisions 1, 3 to 16, 18, 20 and  
 111.11 30, "patient" also means any person who is receiving mental health treatment on an outpatient  
 111.12 basis or in a community support program or other community-based program. "Resident"  
 111.13 means a person who is admitted to a nonacute care facility including extended care facilities,  
 111.14 nursing homes, and boarding care homes for care required because of prolonged mental or  
 111.15 physical illness or disability, recovery from injury or disease, or advancing age. For purposes  
 111.16 of all subdivisions except subdivisions 28 and 29, "resident" also means a person who is  
 111.17 admitted to a facility licensed as a board and lodging facility under Minnesota Rules, parts  
 111.18 4625.0100 to 4625.2355, a boarding care home under sections 144.50 to 144.56, or a  
 111.19 supervised living facility under Minnesota Rules, parts 4665.0100 to 4665.9900, and which  
 111.20 operates a rehabilitation program licensed under chapter 245G or 245I, or Minnesota Rules,  
 111.21 parts 9530.6510 to 9530.6590. For purposes of all subdivisions except subdivisions 20, 28,  
 111.22 29, 32, and 33, "resident" also means a person who is admitted to a facility licensed to  
 111.23 provide intensive residential treatment services or residential crisis stabilization under section  
 111.24 245I.23.

111.25 Sec. 2. Minnesota Statutes 2024, section 169A.284, is amended to read:

111.26 **169A.284 ~~CHEMICAL DEPENDENCY~~ COMPREHENSIVE ASSESSMENT**  
 111.27 **CHARGE; SURCHARGE.**

111.28 Subdivision 1. **When required.** (a) When a court sentences a person convicted of an  
 111.29 offense enumerated in section 169A.70, subdivision 2 (~~chemical use~~ comprehensive  
 111.30 assessment; requirement; form), except as provided in paragraph (c), it shall order the person  
 111.31 to pay the cost of the comprehensive assessment directly to the entity conducting the  
 111.32 assessment or providing the assessment services in an amount determined by the entity  
 111.33 conducting or providing the service and shall impose a ~~chemical dependency~~ comprehensive  
 111.34 assessment charge of \$25. The court may waive the \$25 comprehensive assessment charge,

112.1 but may not waive the cost for the assessment paid directly to the entity conducting the  
112.2 assessment or providing assessment services. A person shall pay an additional surcharge  
112.3 of \$5 if the person is convicted of a violation of section 169A.20 (driving while impaired)  
112.4 within five years of a prior impaired driving conviction or a prior conviction for an offense  
112.5 arising out of an arrest for a violation of section 169A.20 or Minnesota Statutes 1998, section  
112.6 169.121 (driver under influence of alcohol or controlled substance) or 169.129 (aggravated  
112.7 DWI-related violations; penalty). This section applies when the sentence is executed, stayed,  
112.8 or suspended. The court may not waive payment of or authorize payment in installments  
112.9 of the comprehensive assessment charge and surcharge ~~in installments~~ unless it makes  
112.10 written findings on the record that the convicted person is indigent or that the comprehensive  
112.11 assessment charge and surcharge would create undue hardship for the convicted person or  
112.12 that person's immediate family.

112.13 (b) The ~~chemical dependency~~ comprehensive assessment charge and surcharge required  
112.14 under this section are in addition to the surcharge required by section 357.021, subdivision  
112.15 6 (surcharges on criminal and traffic offenders).

112.16 (c) The court must not order the person convicted of an offense enumerated in section  
112.17 169A.70, subdivision 2 (comprehensive assessment; requirement; form), to pay the cost of  
112.18 the comprehensive assessment if the comprehensive assessment conducted is eligible for  
112.19 reimbursement under chapter 254B or 256B.

112.20 Subd. 2. **Distribution of money.** The court administrator shall collect and forward the  
112.21 ~~chemical dependency~~ comprehensive assessment charge and the \$5 surcharge, if any, to  
112.22 the commissioner of management and budget to be deposited in the state treasury and  
112.23 credited to the general fund.

112.24 Sec. 3. Minnesota Statutes 2024, section 245.462, subdivision 4, is amended to read:

112.25 Subd. 4. **Case management service provider.** (a) "Case management service provider"  
112.26 means a case manager or case manager associate employed by the county or other entity  
112.27 authorized by the county board to provide case management services specified in section  
112.28 245.4711.

112.29 (b) A case manager must:

112.30 (1) be skilled in the process of identifying and assessing a wide range of client needs;

112.31 (2) be knowledgeable about local community resources and how to use those resources  
112.32 for the benefit of the client;

113.1 (3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have  
113.2 a bachelor's degree in one of the behavioral sciences or related fields including, but not  
113.3 limited to, social work, psychology, or nursing from an accredited college or university. A  
113.4 case manager who is not a mental health practitioner ~~and~~ or who does not have a bachelor's  
113.5 degree in one of the behavioral sciences or related fields must meet the requirements of  
113.6 paragraph (c); and

113.7 (4) meet the supervision and continuing education requirements described in paragraphs  
113.8 (d), (e), and (f), as applicable.

113.9 (c) Case managers without a bachelor's degree or with a bachelor's degree that is not in  
113.10 one of the behavioral sciences or related fields must meet one of the requirements in clauses  
113.11 (1) to ~~(3)~~ (5):

113.12 (1) have ~~three or~~ four years of experience as a case manager associate as defined in this  
113.13 section;

113.14 (2) be a registered nurse without a bachelor's degree and have a combination of  
113.15 specialized training in psychiatry and work experience consisting of community interaction  
113.16 and involvement or community discharge planning in a mental health setting totaling three  
113.17 years; ~~or~~

113.18 (3) be a person who qualified as a case manager under the 1998 Department of Human  
113.19 Service waiver provision and meet the continuing education and mentoring requirements  
113.20 in this section;

113.21 (4) prior to direct service delivery, complete at least 80 hours of specific training on the  
113.22 characteristics and needs of adults with serious and persistent mental illness that is consistent  
113.23 with national practices standards; or

113.24 (5) prior to direct service delivery, demonstrate competency in practice and knowledge  
113.25 of the characteristics and needs of adults with serious and persistent mental illness, consistent  
113.26 with national practices standards.

113.27 (d) A case manager with at least 2,000 hours of supervised experience in the delivery  
113.28 of services to adults with mental illness must receive regular ongoing supervision and clinical  
113.29 supervision totaling 38 hours per year of which at least one hour per month must be clinical  
113.30 supervision regarding individual service delivery with a case management supervisor. The  
113.31 remaining 26 hours of supervision may be provided by a case manager with two years of  
113.32 experience. Group supervision may not constitute more than one-half of the required  
113.33 supervision hours. Clinical supervision must be documented in the client record.

114.1 (e) A case manager without 2,000 hours of supervised experience in the delivery of  
114.2 services to adults with mental illness must:

114.3 (1) receive clinical supervision regarding individual service delivery from a mental  
114.4 health professional at least one hour per week until the requirement of 2,000 hours of  
114.5 experience is met; and

114.6 (2) complete 40 hours of training approved by the commissioner in case management  
114.7 skills and the characteristics and needs of adults with serious and persistent mental illness.

114.8 (f) A case manager who is not licensed, registered, or certified by a health-related  
114.9 licensing board must receive 30 hours of continuing education and training in mental illness  
114.10 and mental health services every two years.

114.11 (g) A case manager associate (CMA) must:

114.12 (1) work under the direction of a case manager or case management supervisor;

114.13 (2) be at least 21 years of age;

114.14 (3) have at least a high school diploma or its equivalent; and

114.15 (4) meet one of the following criteria:

114.16 (i) have an associate of arts degree in one of the behavioral sciences or human services;

114.17 (ii) be a certified peer specialist under section 256B.0615;

114.18 (iii) be a registered nurse without a bachelor's degree;

114.19 (iv) within the previous ten years, have three years of life experience with serious and  
114.20 persistent mental illness as defined in subdivision 20; or as a child had severe emotional  
114.21 disturbance as defined in section 245.4871, subdivision 6; or have three years life experience  
114.22 as a primary caregiver to an adult with serious and persistent mental illness within the  
114.23 previous ten years;

114.24 (v) have 6,000 hours work experience as a nondegreed state hospital technician; or

114.25 (vi) have at least 6,000 hours of supervised experience in the delivery of services to  
114.26 persons with mental illness.

114.27 Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager  
114.28 after four years of supervised work experience as a case manager associate. Individuals  
114.29 meeting the criteria in item (vi) may qualify as a case manager after three years of supervised  
114.30 experience as a case manager associate.

115.1 (h) A case management associate must meet the following supervision, mentoring, and  
115.2 continuing education requirements:

115.3 (1) have 40 hours of preservice training described under paragraph (e), clause (2);

115.4 (2) receive ~~at least 40~~ annual hours of continuing education in mental illness and mental  
115.5 health services ~~annually; and~~ according to the following schedule, based on years of service  
115.6 as a case management associate:

115.7 (i) at least 40 hours in the first year;

115.8 (ii) at least 30 hours in the second year;

115.9 (iii) at least 20 hours in the third year; and

115.10 (iv) at least 20 hours in the fourth year; and

115.11 (3) receive at least ~~five~~ four hours of ~~mentoring~~ supervision per ~~week~~ month from a case  
115.12 management ~~mentor~~ supervisor.

115.13 ~~A "case management mentor" means a qualified, practicing case manager or case management~~  
115.14 ~~supervisor who teaches or advises and provides intensive training and clinical supervision~~  
115.15 ~~to one or more case manager associates. Mentoring may occur while providing direct services~~  
115.16 ~~to consumers in the office or in the field and may be provided to individuals or groups of~~  
115.17 ~~case manager associates. At least two mentoring hours per week must be individual and~~  
115.18 ~~face-to-face.~~

115.19 (i) A case management supervisor must meet the criteria for mental health professionals,  
115.20 as specified in subdivision 18.

115.21 (j) An immigrant who does not have the qualifications specified in this subdivision may  
115.22 provide case management services to adult immigrants with serious and persistent mental  
115.23 illness who are members of the same ethnic group as the case manager if the person:

115.24 (1) is currently enrolled in and is actively pursuing credits toward the completion of a  
115.25 bachelor's degree in one of the behavioral sciences or a related field including, but not  
115.26 limited to, social work, psychology, or nursing from an accredited college or university;

115.27 (2) completes 40 hours of training as specified in this subdivision; and

115.28 (3) receives clinical supervision at least once a week until the requirements of this  
115.29 subdivision are met.

116.1 Sec. 4. Minnesota Statutes 2024, section 245.462, subdivision 20, is amended to read:

116.2 Subd. 20. **Mental illness.** (a) "Mental illness" means an organic disorder of the brain or  
116.3 a clinically significant disorder of thought, mood, perception, orientation, memory, or  
116.4 behavior that is detailed in a diagnostic codes list published by the commissioner, and that  
116.5 seriously limits a person's capacity to function in primary aspects of daily living such as  
116.6 personal relations, living arrangements, work, and recreation.

116.7 (b) An "adult with acute mental illness" means an adult who has a mental illness that is  
116.8 serious enough to require prompt intervention.

116.9 (c) For purposes of enrolling in case management and community support services, a  
116.10 "person with serious and persistent mental illness" means an adult who has a mental illness  
116.11 and meets at least one of the following criteria:

116.12 (1) the adult has undergone ~~two~~ one or more episodes of inpatient, residential, or crisis  
116.13 residential care for a mental illness within the preceding ~~24~~ 12 months;

116.14 (2) the adult has experienced a continuous psychiatric hospitalization or residential  
116.15 treatment exceeding six months' duration within the preceding 12 months;

116.16 (3) the adult has been treated by a crisis team two or more times within the preceding  
116.17 24 months;

116.18 (4) the adult:

116.19 (i) has a diagnosis of schizophrenia, bipolar disorder, major depression, schizoaffective  
116.20 disorder, post-traumatic stress disorder, or borderline personality disorder;

116.21 (ii) indicates a significant impairment in functioning; and

116.22 (iii) has a written opinion from a mental health professional, in the last three years,  
116.23 stating that the adult is reasonably likely to have future episodes requiring inpatient or  
116.24 residential treatment, of a frequency described in clause (1) or (2), or the need for in-home  
116.25 services to remain in one's home, unless ongoing case management or community support  
116.26 services are provided;

116.27 (5) the adult has, in the last ~~three~~ five years, been committed by a court as a person ~~who~~  
116.28 ~~is mentally ill~~ with a mental illness under chapter 253B, or the adult's commitment has been  
116.29 stayed or continued; or

116.30 ~~(6) the adult (i) was eligible under clauses (1) to (5), but the specified time period has~~  
116.31 ~~expired or the adult was eligible as a child under section 245.4871, subdivision 6; and (ii)~~  
116.32 ~~has a written opinion from a mental health professional, in the last three years, stating that~~

117.1 ~~the adult is reasonably likely to have future episodes requiring inpatient or residential~~  
117.2 ~~treatment, of a frequency described in clause (1) or (2), unless ongoing case management~~  
117.3 ~~or community support services are provided; or~~

117.4 ~~(7)~~ (6) the adult was eligible as a child under section 245.4871, subdivision 6, and is  
117.5 age 21 or younger.

117.6 (d) For purposes of enrolling in case management and community support services, a  
117.7 "person with a complex post-traumatic stress disorder" or "C-PTSD" means an adult who  
117.8 has a mental illness and meets the following criteria:

117.9 (1) the adult has post-traumatic stress disorder (PTSD) symptoms that significantly  
117.10 interfere with daily functioning related to intergenerational trauma, racial trauma, or  
117.11 unresolved historical grief; and

117.12 (2) the adult has a written opinion from a mental health professional that includes  
117.13 documentation of:

117.14 (i) culturally sensitive assessments or screenings and identification of intergenerational  
117.15 trauma, racial trauma, or unresolved historical grief;

117.16 (ii) significant impairment in functioning due to the PTSD symptoms that meet C-PTSD  
117.17 condition eligibility; and

117.18 (iii) increasing concerns within the last three years that indicates the adult is at a  
117.19 reasonable likelihood of experiencing significant episodes of PTSD with increased frequency,  
117.20 impacting daily functioning unless mitigated by targeted case management or community  
117.21 support services.

117.22 (e) Adults may continue to receive case management or community support services if,  
117.23 in the written opinion of a mental health professional, the person needs case management  
117.24 or community support services to maintain the person's recovery.

117.25 **EFFECTIVE DATE.** Paragraph (d) is effective upon federal approval. The commissioner  
117.26 of human services shall notify the revisor of statutes when federal approval is obtained.

117.27 Sec. 5. Minnesota Statutes 2024, section 245.467, subdivision 4, is amended to read:

117.28 Subd. 4. **Referral for case management.** Each provider of emergency services, day  
117.29 treatment services, outpatient treatment, community support services, residential treatment,  
117.30 acute care hospital inpatient treatment, or regional treatment center inpatient treatment must  
117.31 inform each of its clients with serious and persistent mental illness or a complex  
117.32 post-traumatic stress disorder of the availability and potential benefits to the client of case

118.1 management. If the client consents, the provider must refer the client by notifying the county  
118.2 employee designated by the county board to coordinate case management activities of the  
118.3 client's name and address and by informing the client of whom to contact to request case  
118.4 management. The provider must document compliance with this subdivision in the client's  
118.5 record.

118.6 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
118.7 of human services shall notify the revisor of statutes when federal approval is obtained.

118.8 Sec. 6. Minnesota Statutes 2024, section 245.469, is amended to read:

118.9 **245.469 EMERGENCY SERVICES.**

118.10 Subdivision 1. **Availability of emergency services.** (a) County boards must provide or  
118.11 contract for enough emergency services within the county to meet the needs of adults,  
118.12 children, and families in the county who are experiencing an emotional crisis or mental  
118.13 illness. Clients must not be charged for services provided. Emergency service providers  
118.14 ~~must not delay the timely provision of emergency services to a client because of the~~  
118.15 ~~unwillingness or inability of the client to pay for services~~ meet the qualifications under  
118.16 section 256B.0624, subdivision 4. Emergency services must include assessment, crisis  
118.17 intervention, and appropriate case disposition. Emergency services must:

118.18 (1) promote the safety and emotional stability of each client;

118.19 (2) minimize further deterioration of each client;

118.20 (3) help each client to obtain ongoing care and treatment;

118.21 (4) prevent placement in settings that are more intensive, costly, or restrictive than  
118.22 necessary and appropriate to meet client needs; and

118.23 (5) provide support, psychoeducation, and referrals to each client's family members,  
118.24 service providers, and other third parties on behalf of the client in need of emergency  
118.25 services.

118.26 (b) If a county provides engagement services under section 253B.041, the county's  
118.27 emergency service providers must refer clients to engagement services when the client  
118.28 meets the criteria for engagement services.

118.29 Subd. 2. **Specific requirements.** (a) The county board shall require that all service  
118.30 providers of emergency services to adults or children with mental illness provide immediate  
118.31 direct access to a mental health professional during regular business hours. For evenings,

119.1 weekends, and holidays, the service may be by direct toll-free telephone access to a mental  
119.2 health professional, clinical trainee, or mental health practitioner.

119.3 (b) The commissioner may waive the requirement in paragraph (a) that the evening,  
119.4 weekend, and holiday service be provided by a mental health professional, clinical trainee,  
119.5 or mental health practitioner if the county documents that:

119.6 (1) mental health professionals, clinical trainees, or mental health practitioners are  
119.7 unavailable to provide this service;

119.8 (2) services are provided by a designated person with training in human services who  
119.9 receives treatment supervision from a mental health professional; and

119.10 (3) the service provider is not also the provider of fire and public safety emergency  
119.11 services.

119.12 (c) The commissioner may waive the requirement in paragraph (b), clause (3), that the  
119.13 evening, weekend, and holiday service not be provided by the provider of fire and public  
119.14 safety emergency services if:

119.15 (1) every person who will be providing the first telephone contact has received at least  
119.16 eight hours of training on emergency mental health services approved by the commissioner;

119.17 (2) every person who will be providing the first telephone contact will annually receive  
119.18 at least four hours of continued training on emergency mental health services approved by  
119.19 the commissioner;

119.20 (3) the local social service agency has provided public education about available  
119.21 emergency mental health services and can assure potential users of emergency services that  
119.22 their calls will be handled appropriately;

119.23 (4) the local social service agency agrees to provide the commissioner with accurate  
119.24 data on the number of emergency mental health service calls received;

119.25 (5) the local social service agency agrees to monitor the frequency and quality of  
119.26 emergency services; and

119.27 (6) the local social service agency describes how it will comply with paragraph (d).

119.28 (d) Whenever emergency service during nonbusiness hours is provided by anyone other  
119.29 than a mental health professional, a mental health professional must be available on call for  
119.30 an emergency assessment and crisis intervention services, and must be available for at least  
119.31 telephone consultation within 30 minutes.

120.1 Subd. 3. **Mental health crisis services.** The commissioner of human services shall  
120.2 increase access to mental health crisis services for children and adults. In order to increase  
120.3 access, the commissioner must:

120.4 (1) ~~develop a central phone number where calls can be routed to the appropriate crisis~~  
120.5 ~~services~~ promote the 988 Lifeline;

120.6 (2) provide telephone consultation 24 hours a day to mobile crisis teams who are serving  
120.7 people with traumatic brain injury or intellectual disabilities who are experiencing a mental  
120.8 health crisis;

120.9 (3) expand crisis services across the state, including rural areas of the state and examining  
120.10 access per population;

120.11 (4) establish and implement state standards and requirements for crisis services as outlined  
120.12 in section 256B.0624; and

120.13 (5) provide grants to adult mental health initiatives, counties, tribes, or community mental  
120.14 health providers to establish new mental health crisis residential service capacity.

120.15 Priority will be given to regions that do not have a mental health crisis residential services  
120.16 program, do not have an inpatient psychiatric unit within the region, do not have an inpatient  
120.17 psychiatric unit within 90 miles, or have a demonstrated need based on the number of crisis  
120.18 residential or intensive residential treatment beds available to meet the needs of the residents  
120.19 in the region. At least 50 percent of the funds must be distributed to programs in rural  
120.20 Minnesota. Grant funds may be used for start-up costs, including but not limited to  
120.21 renovations, furnishings, and staff training. Grant applications shall provide details on how  
120.22 the intended service will address identified needs and shall demonstrate collaboration with  
120.23 crisis teams, other mental health providers, hospitals, and police.

120.24 Sec. 7. Minnesota Statutes 2024, section 245.4711, subdivision 1, is amended to read:

120.25 Subdivision 1. **Availability of case management services.** (a) ~~By January 1, 1989,~~ The  
120.26 county board shall provide case management services for all adults with serious and persistent  
120.27 mental illness or a complex post-traumatic stress disorder who are residents of the county  
120.28 and who request or consent to the services and to each adult for whom the court appoints a  
120.29 case manager. Staffing ratios must be sufficient to serve the needs of the clients. The case  
120.30 manager must meet the requirements in section 245.462, subdivision 4.

120.31 (b) Case management services provided to adults with serious and persistent mental  
120.32 illness or a complex post-traumatic stress disorder eligible for medical assistance must be

121.1 billed to the medical assistance program under sections 256B.02, subdivision 8, and  
121.2 256B.0625.

121.3 (c) Case management services are eligible for reimbursement under the medical assistance  
121.4 program. Costs associated with mentoring, supervision, and continuing education may be  
121.5 included in the reimbursement rate methodology used for case management services under  
121.6 the medical assistance program.

121.7 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
121.8 of human services shall notify the revisor of statutes when federal approval is obtained.

121.9 Sec. 8. Minnesota Statutes 2024, section 245.4711, subdivision 4, is amended to read:

121.10 Subd. 4. **Individual community support plan.** (a) The case manager must develop an  
121.11 individual community support plan for each adult that incorporates the client's individual  
121.12 treatment plan. The individual treatment plan may not be a substitute for the development  
121.13 of an individual community support plan. The individual community support plan must be  
121.14 developed within 30 days of client intake and reviewed at least every 180 days after it is  
121.15 developed, unless the case manager receives a written request from the client or the client's  
121.16 family for a review of the plan every 90 days after it is developed. The case manager is  
121.17 responsible for developing the individual community support plan based on a diagnostic  
121.18 assessment and a functional assessment and for implementing and monitoring the delivery  
121.19 of services according to the individual community support plan. To the extent possible, the  
121.20 adult with serious and persistent mental illness or a complex post-traumatic stress disorder,  
121.21 the person's family, advocates, service providers, and significant others must be involved  
121.22 in all phases of development and implementation of the individual community support plan.

121.23 (b) The client's individual community support plan must state:

121.24 (1) the goals of each service;

121.25 (2) the activities for accomplishing each goal;

121.26 (3) a schedule for each activity; and

121.27 (4) the frequency of face-to-face contacts by the case manager, as appropriate to client  
121.28 need and the implementation of the individual community support plan.

121.29 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
121.30 of human services shall notify the revisor of statutes when federal approval is obtained.

122.1 Sec. 9. Minnesota Statutes 2024, section 245.4712, subdivision 1, is amended to read:

122.2 Subdivision 1. **Availability of community support services.** (a) County boards must  
122.3 provide or contract for sufficient community support services within the county to meet the  
122.4 needs of adults with serious and persistent mental illness or a complex post-traumatic stress  
122.5 disorder who are residents of the county. Adults may be required to pay a fee according to  
122.6 section 245.481. The community support services program must be designed to improve  
122.7 the ability of adults with serious and persistent mental illness or a complex post-traumatic  
122.8 stress disorder to:

- 122.9 (1) find and maintain competitive employment;
- 122.10 (2) handle basic activities of daily living;
- 122.11 (3) participate in leisure time activities;
- 122.12 (4) set goals and plans; and
- 122.13 (5) obtain and maintain appropriate living arrangements.

122.14 The community support services program must also be designed to reduce the need for  
122.15 and use of more intensive, costly, or restrictive placements both in number of admissions  
122.16 and length of stay.

122.17 (b) Community support services are those services that are supportive in nature and not  
122.18 necessarily treatment oriented, and include:

- 122.19 (1) conducting outreach activities such as home visits, health and wellness checks, and  
122.20 problem solving;
- 122.21 (2) connecting people to resources to meet their basic needs;
- 122.22 (3) finding, securing, and supporting people in their housing;
- 122.23 (4) attaining and maintaining health insurance benefits;
- 122.24 (5) assisting with job applications, finding and maintaining employment, and securing  
122.25 a stable financial situation;
- 122.26 (6) fostering social support, including support groups, mentoring, peer support, and other  
122.27 efforts to prevent isolation and promote recovery; and
- 122.28 (7) educating about mental illness, treatment, and recovery.

122.29 (c) Community support services shall use all available funding streams. The county shall  
122.30 maintain the level of expenditures for this program, as required under section 245.4835.  
122.31 County boards must continue to provide funds for those services not covered by other

123.1 funding streams and to maintain an infrastructure to carry out these services. The county is  
123.2 encouraged to fund evidence-based practices such as Individual Placement and Supported  
123.3 Employment and Illness Management and Recovery.

123.4 (d) The commissioner shall collect data on community support services programs,  
123.5 including, but not limited to, demographic information such as age, sex, race, the number  
123.6 of people served, and information related to housing, employment, hospitalization, symptoms,  
123.7 and satisfaction with services.

123.8 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
123.9 of human services shall notify the revisor of statutes when federal approval is obtained.

123.10 Sec. 10. Minnesota Statutes 2024, section 245.4712, subdivision 3, is amended to read:

123.11 Subd. 3. **Benefits assistance.** The county board must offer to help adults with serious  
123.12 and persistent mental illness or a complex post-traumatic stress disorder in applying for  
123.13 state and federal benefits, including Supplemental Security Income, medical assistance,  
123.14 Medicare, general assistance, and Minnesota supplemental aid. The help must be offered  
123.15 as part of the community support program available to adults with serious and persistent  
123.16 mental illness or a complex post-traumatic stress disorder for whom the county is financially  
123.17 responsible and who may qualify for these benefits.

123.18 Sec. 11. Minnesota Statutes 2024, section 245.4871, subdivision 4, is amended to read:

123.19 Subd. 4. **Case management service provider.** (a) "Case management service provider"  
123.20 means a case manager or case manager associate employed by the county or other entity  
123.21 authorized by the county board to provide case management services specified in subdivision  
123.22 3 for the child with severe emotional disturbance and the child's family.

123.23 (b) A case manager must:

123.24 (1) have experience and training in working with children;

123.25 (2) be a mental health practitioner under section 245I.04, subdivision 4, or have at least  
123.26 a bachelor's degree in one of the behavioral sciences or a related field including, but not  
123.27 limited to, social work, psychology, or nursing from an accredited college or university or  
123.28 meet the requirements of paragraph (d);

123.29 (3) have experience and training in identifying and assessing a wide range of children's  
123.30 needs;

124.1 (4) be knowledgeable about local community resources and how to use those resources  
124.2 for the benefit of children and their families; and

124.3 (5) meet the supervision and continuing education requirements of paragraphs (e), (f),  
124.4 and (g), as applicable.

124.5 (c) A case manager may be a member of any professional discipline that is part of the  
124.6 local system of care for children established by the county board.

124.7 (d) A case manager ~~without~~ who is not a mental health practitioner and does not have  
124.8 a bachelor's degree or who has a bachelor's degree that is not in one of the behavioral sciences  
124.9 or related fields must meet one of the requirements in clauses (1) to ~~(3)~~ (5):

124.10 (1) have three or four years of experience as a case manager associate;

124.11 (2) be a registered nurse without a bachelor's degree who has a combination of specialized  
124.12 training in psychiatry and work experience consisting of community interaction and  
124.13 involvement or community discharge planning in a mental health setting totaling three years;  
124.14 ~~or~~

124.15 (3) be a person who qualified as a case manager under the 1998 Department of Human  
124.16 Services waiver provision and meets the continuing education, supervision, and mentoring  
124.17 requirements in this section;

124.18 (4) prior to direct service delivery, complete at least 80 hours of specific training on the  
124.19 characteristics and needs of children with serious mental illness that is consistent with  
124.20 national practices standards; or

124.21 (5) prior to direct service delivery, demonstrate competency in practice and knowledge  
124.22 of the characteristics and needs of children with serious mental illness, consistent with  
124.23 national practices standards.

124.24 (e) A case manager with at least 2,000 hours of supervised experience in the delivery  
124.25 of mental health services to children must receive regular ongoing supervision and clinical  
124.26 supervision totaling 38 hours per year, of which at least one hour per month must be clinical  
124.27 supervision regarding individual service delivery with a case management supervisor. The  
124.28 other 26 hours of supervision may be provided by a case manager with two years of  
124.29 experience. Group supervision may not constitute more than one-half of the required  
124.30 supervision hours.

124.31 (f) A case manager without 2,000 hours of supervised experience in the delivery of  
124.32 mental health services to children with emotional disturbance must:

125.1 (1) begin 40 hours of training approved by the commissioner of human services in case  
125.2 management skills and in the characteristics and needs of children with severe emotional  
125.3 disturbance before beginning to provide case management services; and

125.4 (2) receive clinical supervision regarding individual service delivery from a mental  
125.5 health professional at least one hour each week until the requirement of 2,000 hours of  
125.6 experience is met.

125.7 (g) A case manager who is not licensed, registered, or certified by a health-related  
125.8 licensing board must receive 30 hours of continuing education and training in severe  
125.9 emotional disturbance and mental health services every two years.

125.10 (h) Clinical supervision must be documented in the child's record. When the case manager  
125.11 is not a mental health professional, the county board must provide or contract for needed  
125.12 clinical supervision.

125.13 (i) The county board must ensure that the case manager has the freedom to access and  
125.14 coordinate the services within the local system of care that are needed by the child.

125.15 (j) A case manager associate (CMA) must:

125.16 (1) work under the direction of a case manager or case management supervisor;

125.17 (2) be at least 21 years of age;

125.18 (3) have at least a high school diploma or its equivalent; and

125.19 (4) meet one of the following criteria:

125.20 (i) have an associate of arts degree in one of the behavioral sciences or human services;

125.21 (ii) be a registered nurse without a bachelor's degree;

125.22 (iii) have three years of life experience as a primary caregiver to a child with serious  
125.23 emotional disturbance as defined in subdivision 6 within the previous ten years;

125.24 (iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

125.25 (v) have 6,000 hours of supervised work experience in the delivery of mental health  
125.26 services to children with emotional disturbances; hours worked as a mental health behavioral  
125.27 aide I or II under section 256B.0943, subdivision 7, may count toward the 6,000 hours of  
125.28 supervised work experience.

125.29 Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager  
125.30 after four years of supervised work experience as a case manager associate. Individuals

126.1 meeting the criteria in item (v) may qualify as a case manager after three years of supervised  
126.2 experience as a case manager associate.

126.3 (k) Case manager associates must meet the following supervision, mentoring, and  
126.4 continuing education requirements;

126.5 (1) have 40 hours of preservice training described under paragraph (f), clause (1);

126.6 (2) receive at least 40 hours of continuing education in severe emotional disturbance  
126.7 and mental health service annually; and

126.8 (3) receive at least five hours of mentoring per week from a case management mentor.

126.9 A "case management mentor" means a qualified, practicing case manager or case management  
126.10 supervisor who teaches or advises and provides intensive training and clinical supervision  
126.11 to one or more case manager associates. Mentoring may occur while providing direct services  
126.12 to consumers in the office or in the field and may be provided to individuals or groups of  
126.13 case manager associates. At least two mentoring hours per week must be individual and  
126.14 face-to-face.

126.15 (l) A case management supervisor must meet the criteria for a mental health professional  
126.16 as specified in subdivision 27.

126.17 (m) An immigrant who does not have the qualifications specified in this subdivision  
126.18 may provide case management services to child immigrants with severe emotional  
126.19 disturbance of the same ethnic group as the immigrant if the person:

126.20 (1) is currently enrolled in and is actively pursuing credits toward the completion of a  
126.21 bachelor's degree in one of the behavioral sciences or related fields at an accredited college  
126.22 or university;

126.23 (2) completes 40 hours of training as specified in this subdivision; and

126.24 (3) receives clinical supervision at least once a week until the requirements of obtaining  
126.25 a bachelor's degree and 2,000 hours of supervised experience are met.

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

126.27 Sec. 12. Minnesota Statutes 2024, section 245.4871, subdivision 5, is amended to read:

126.28 Subd. 5. **Child.** "Child" means a person under 18 years of age, or a person 18 years of  
126.29 age or older and under 21 years of age receiving continuous children's mental health targeted  
126.30 case management services as defined in section 245.2875, subdivision 8.

127.1 Sec. 13. Minnesota Statutes 2024, section 245.4871, is amended by adding a subdivision  
127.2 to read:

127.3 Subd. 7a. **Clinical supervision.** "Clinical supervision" means the oversight responsibility  
127.4 for individual treatment plans and individual mental health service delivery, including  
127.5 oversight provided by the case manager. Clinical supervision must be provided by a mental  
127.6 health professional. The supervising mental health professional must cosign an individual  
127.7 treatment plan, and their name must be documented in the client's record.

127.8 Sec. 14. Minnesota Statutes 2024, section 245.4871, subdivision 31, is amended to read:

127.9 Subd. 31. **Professional home-based family treatment.** (a) "Professional home-based  
127.10 family treatment" means intensive mental health services provided to children because of  
127.11 ~~an emotional disturbance~~ a mental illness: (1) who are at risk of ~~out-of-home placement~~  
127.12 residential treatment or therapeutic foster care; (2) who are in ~~out-of-home placement~~  
127.13 residential treatment or therapeutic foster care; or (3) who are returning from ~~out-of-home~~  
127.14 ~~placement~~ residential treatment or therapeutic foster care.

127.15 (b) Services are provided to the child and the child's family primarily in the child's home  
127.16 environment. Services may also be provided in the child's school, child care setting, or other  
127.17 community setting appropriate to the child. Services must be provided on an individual  
127.18 family basis, must be child-oriented and family-oriented, and must be designed using  
127.19 information from diagnostic and functional assessments to meet the specific mental health  
127.20 needs of the child and the child's family. Services must be coordinated with other services  
127.21 provided to the child and family.

127.22 (c) Examples of services are: (1) individual therapy; (2) family therapy; (3) client  
127.23 outreach; (4) assistance in developing individual living skills; (5) assistance in developing  
127.24 parenting skills necessary to address the needs of the child; (6) assistance with leisure and  
127.25 recreational services; (7) crisis planning, including crisis respite care and arranging for crisis  
127.26 placement; and (8) assistance in locating respite and child care. Services must be coordinated  
127.27 with other services provided to the child and family.

127.28 Sec. 15. Minnesota Statutes 2024, section 245.4874, subdivision 1, is amended to read:

127.29 Subdivision 1. **Duties of county board.** (a) The county board must:

127.30 (1) develop a system of affordable and locally available children's mental health services  
127.31 according to sections 245.487 to 245.4889;

128.1 (2) consider the assessment of unmet needs in the county as reported by the local  
128.2 children's mental health advisory council under section 245.4875, subdivision 5, paragraph  
128.3 (b), clause (3). The county shall provide, upon request of the local children's mental health  
128.4 advisory council, readily available data to assist in the determination of unmet needs;

128.5 (3) assure that parents and providers in the county receive information about how to  
128.6 gain access to services provided according to sections 245.487 to 245.4889;

128.7 (4) coordinate the delivery of children's mental health services with services provided  
128.8 by social services, education, corrections, health, and vocational agencies to improve the  
128.9 availability of mental health services to children and the cost-effectiveness of their delivery;

128.10 (5) assure that mental health services delivered according to sections 245.487 to 245.4889  
128.11 are delivered expeditiously and are appropriate to the child's diagnostic assessment and  
128.12 individual treatment plan;

128.13 (6) provide for case management services to each child with ~~severe emotional disturbance~~  
128.14 serious mental illness according to sections 245.486; 245.4871, subdivisions 3 and 4; and  
128.15 245.4881, subdivisions 1, 3, and 5;

128.16 (7) provide for screening of each child under section 245.4885 upon admission to a  
128.17 residential treatment facility, ~~acute care hospital inpatient treatment, or informal admission~~  
128.18 ~~to a regional treatment center;~~

128.19 (8) prudently administer grants and purchase-of-service contracts that the county board  
128.20 determines are necessary to fulfill its responsibilities under sections 245.487 to 245.4889;

128.21 (9) assure that mental health professionals, mental health practitioners, and case managers  
128.22 employed by or under contract to the county to provide mental health services are qualified  
128.23 under section 245.4871;

128.24 (10) assure that children's mental health services are coordinated with adult mental health  
128.25 services specified in sections 245.461 to 245.486 so that a continuum of mental health  
128.26 services is available to serve persons with mental illness, regardless of the person's age;

128.27 (11) assure that culturally competent mental health consultants are used as necessary to  
128.28 assist the county board in assessing and providing appropriate treatment for children of  
128.29 cultural or racial minority heritage; and

128.30 (12) consistent with section 245.486, arrange for or provide a children's mental health  
128.31 screening for:

128.32 (i) a child receiving child protective services;

129.1 (ii) a child in ~~out-of-home placement~~ residential treatment or therapeutic foster care;

129.2 (iii) a child for whom parental rights have been terminated;

129.3 (iv) a child found to be delinquent; or

129.4 (v) a child found to have committed a juvenile petty offense for the third or subsequent  
129.5 time.

129.6 A children's mental health screening is not required when a screening or diagnostic  
129.7 assessment has been performed within the previous 180 days, or the child is currently under  
129.8 the care of a mental health professional.

129.9 (b) When a child is receiving protective services or is in ~~out-of-home placement~~  
129.10 residential treatment or foster care, the court or county agency must notify a parent or  
129.11 guardian whose parental rights have not been terminated of the potential mental health  
129.12 screening and the option to prevent the screening by notifying the court or county agency  
129.13 in writing.

129.14 (c) When a child is found to be delinquent or a child is found to have committed a  
129.15 juvenile petty offense for the third or subsequent time, the court or county agency must  
129.16 obtain written informed consent from the parent or legal guardian before a screening is  
129.17 conducted unless the court, notwithstanding the parent's failure to consent, determines that  
129.18 the screening is in the child's best interest.

129.19 (d) The screening shall be conducted with a screening instrument approved by the  
129.20 commissioner of human services according to criteria that are updated and issued annually  
129.21 to ensure that approved screening instruments are valid and useful for child welfare and  
129.22 juvenile justice populations. Screenings shall be conducted by a mental health practitioner  
129.23 as defined in section 245.4871, subdivision 26, or a probation officer or local social services  
129.24 agency staff person who is trained in the use of the screening instrument. Training in the  
129.25 use of the instrument shall include:

129.26 (1) training in the administration of the instrument;

129.27 (2) the interpretation of its validity given the child's current circumstances;

129.28 (3) the state and federal data practices laws and confidentiality standards;

129.29 (4) the parental consent requirement; and

129.30 (5) providing respect for families and cultural values.

129.31 If the screen indicates a need for assessment, the child's family, or if the family lacks  
129.32 mental health insurance, the local social services agency, in consultation with the child's

130.1 family, shall have conducted a diagnostic assessment, including a functional assessment.  
130.2 The administration of the screening shall safeguard the privacy of children receiving the  
130.3 screening and their families and shall comply with the Minnesota Government Data Practices  
130.4 Act, chapter 13, and the federal Health Insurance Portability and Accountability Act of  
130.5 1996, Public Law 104-191. Screening results are classified as private data on individuals,  
130.6 as defined by section 13.02, subdivision 12. The county board or Tribal nation may provide  
130.7 the commissioner with access to the screening results for the purposes of program evaluation  
130.8 and improvement.

130.9 (e) When the county board refers clients to providers of children's therapeutic services  
130.10 and supports under section 256B.0943, the county board must clearly identify the desired  
130.11 services components not covered under section 256B.0943 and identify the reimbursement  
130.12 source for those requested services, the method of payment, and the payment rate to the  
130.13 provider.

130.14 Sec. 16. Minnesota Statutes 2024, section 245.4881, subdivision 3, is amended to read:

130.15 Subd. 3. **Duties of case manager.** (a) Upon a determination of eligibility for case  
130.16 management services, the case manager shall develop an individual family community  
130.17 support plan for a child as specified in subdivision 4, review the child's progress, ~~and~~ monitor  
130.18 the provision of services, and if the child and parent or legal guardian consent, complete a  
130.19 written functional assessment as defined by section 245.4871, subdivision 18a. If services  
130.20 are to be provided in a host county that is not the county of financial responsibility, the case  
130.21 manager shall consult with the host county and obtain a letter demonstrating the concurrence  
130.22 of the host county regarding the provision of services.

130.23 (b) The case manager shall note in the child's record the services needed by the child  
130.24 and the child's family, the services requested by the family, services that are not available,  
130.25 and the unmet needs of the child and child's family. The case manager shall note this  
130.26 provision in the child's record.

130.27 Sec. 17. Minnesota Statutes 2024, section 245.4901, subdivision 3, is amended to read:

130.28 Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities  
130.29 and related expenses may include but are not limited to:

130.30 (1) identifying and diagnosing mental health conditions and substance use disorders of  
130.31 students;

131.1 (2) delivering mental health and substance use disorder treatment and services to students  
131.2 and their families, including via telehealth consistent with section 256B.0625, subdivision  
131.3 3b;

131.4 (3) supporting families in meeting their child's needs, including accessing needed mental  
131.5 health services to support the parent in caregiving and navigating health care, social service,  
131.6 and juvenile justice systems;

131.7 (4) providing transportation for students receiving school-linked behavioral health  
131.8 services when school is not in session;

131.9 (5) building the capacity of schools to meet the needs of students with mental health and  
131.10 substance use disorder concerns, including school staff development activities for licensed  
131.11 and nonlicensed staff; and

131.12 (6) purchasing equipment, connection charges, on-site coordination, set-up fees, and  
131.13 site fees in order to deliver school-linked behavioral health services via telehealth.

131.14 (b) Grantees shall obtain all available third-party reimbursement sources as a condition  
131.15 of receiving a grant. For purposes of this grant program, a third-party reimbursement source  
131.16 excludes a public school as defined in section 120A.20, subdivision 1. Grantees shall serve  
131.17 students regardless of health coverage status or ability to pay.

131.18 Sec. 18. [245.4904] INTERMEDIATE SCHOOL DISTRICT BEHAVIORAL  
131.19 HEALTH GRANT PROGRAM.

131.20 Subdivision 1. Establishment. The commissioner of human services must establish a  
131.21 grant program to improve behavioral health outcomes for youth attending a qualifying  
131.22 school unit and to build the capacity of schools to support student and teacher needs in the  
131.23 classroom. For the purposes of this section, "qualifying school unit" means an intermediate  
131.24 school district organized under section 136D.01.

131.25 Subd. 2. Eligible applicants. An eligible applicant is an intermediate school district  
131.26 organized under section 136D.01, and a partner entity or provider that has demonstrated  
131.27 capacity to serve the youth identified in subdivision 1 that is:

131.28 (1) a mental health clinic certified under section 245I.20;

131.29 (2) a community mental health center under section 256B.0625, subdivision 5;

131.30 (3) an Indian health service facility or a facility owned and operated by a Tribe or Tribal  
131.31 organization operating under United States Code, title 25, section 5321;

132.1 (4) a provider of children's therapeutic services and supports as defined in section  
132.2 256B.0943;

132.3 (5) enrolled in medical assistance as a mental health or substance use disorder provider  
132.4 agency and employs at least two full-time equivalent mental health professionals qualified  
132.5 according to section 245I.04, subdivision 2, or two alcohol and drug counselors licensed or  
132.6 exempt from licensure under chapter 148F who are qualified to provide clinical services to  
132.7 children and families;

132.8 (6) licensed under chapter 245G and in compliance with the applicable requirements in  
132.9 chapters 245A, 245C, and 260E; section 626.557; and Minnesota Rules, chapter 9544; or

132.10 (7) a licensed professional in private practice as defined in section 245G.01, subdivision  
132.11 17, who meets the requirements of section 254B.05, subdivision 1, paragraph (b).

132.12 Subd. 3. **Allowable grant activities and related expenses.** (a) Allowable grant activities  
132.13 and related expenses include but are not limited to:

132.14 (1) identifying mental health conditions and substance use disorders of students;

132.15 (2) delivering mental health and substance use disorder treatment and supportive services  
132.16 to students and their families within the classroom, including via telehealth consistent with  
132.17 section 256B.0625, subdivision 3b;

132.18 (3) delivering therapeutic interventions and customizing an array of supplementary  
132.19 learning experiences for students;

132.20 (4) supporting families in meeting their child's needs, including navigating health care,  
132.21 social service, and juvenile justice systems;

132.22 (5) providing transportation for students receiving behavioral health services when school  
132.23 is not in session;

132.24 (6) building the capacity of schools to meet the needs of students with mental health and  
132.25 substance use disorder concerns, including school staff development activities for licensed  
132.26 and nonlicensed staff; and

132.27 (7) purchasing equipment, connection charges, on-site coordination, set-up fees, and  
132.28 site fees in order to deliver school-linked behavioral health services via telehealth.

132.29 (b) Grantees must obtain all available third-party reimbursement sources as a condition  
132.30 of receiving grant funds. For purposes of this grant program, a third-party reimbursement  
132.31 source does not include a public school as defined in section 120A.20, subdivision 1. Grantees  
132.32 shall serve students regardless of health coverage status or ability to pay.

133.1 Subd. 4. Calculating the share of the appropriation. (a) Grants must be awarded to  
 133.2 qualifying school units proportionately.

133.3 (b) The commissioner must calculate the share of the appropriation to be used in each  
 133.4 qualifying school unit by multiplying the total appropriation going to the grantees by the  
 133.5 qualifying school unit's average daily membership in a setting of federal instructional level  
 133.6 4 or higher and then dividing by the total average daily membership in a setting of federal  
 133.7 instructional level 4 or higher for the same year for all qualifying school units.

133.8 Subd. 5. Data collection and outcome measurement. Grantees must provide data to  
 133.9 the commissioner for the purpose of evaluating the Intermediate School District Behavioral  
 133.10 Health Innovation grant program. The commissioner must consult with grantees to develop  
 133.11 outcome measures for program capacity and performance.

133.12 Sec. 19. Minnesota Statutes 2024, section 245.4907, subdivision 3, is amended to read:

133.13 Subd. 3. Allowable grant activities. Grantees must use grant funding to provide training  
 133.14 for mental health ~~certified~~ family peer ~~specialists~~ specialist candidates and continuing  
 133.15 education to certified family peer specialists as specified in section 256B.0616, subdivision  
 133.16 5.

133.17 Sec. 20. Minnesota Statutes 2024, section 245.735, subdivision 3b, is amended to read:

133.18 Subd. 3b. Exemptions to host county approval. Notwithstanding any other law that  
 133.19 requires a county contract or other form of county approval for a service listed in subdivision  
 133.20 3, paragraph (d), clause (8), a CCBHC that meets the requirements of this section may enroll  
 133.21 as a provider of mental health crisis response services under section 256B.0624 and receive  
 133.22 the prospective payment under section 256B.0625, subdivision 5m, for that service without  
 133.23 a county contract or county approval.

133.24 Sec. 21. Minnesota Statutes 2024, section 245G.05, subdivision 1, is amended to read:

133.25 Subdivision 1. Comprehensive assessment. (a) A comprehensive assessment of the  
 133.26 client's substance use disorder must be administered face-to-face ~~by an alcohol and drug~~  
 133.27 ~~counselor~~ within five calendar days from the day of service initiation for a residential  
 133.28 program or by the end of the fifth day on which a treatment service is provided in a  
 133.29 nonresidential program. The number of days to complete the comprehensive assessment  
 133.30 excludes the day of service initiation.

133.31 (b) A comprehensive assessment must be administered by:

- 134.1 (1) an alcohol and drug counselor;
- 134.2 (2) a mental health professional who meets the qualifications under section 245I.04,
- 134.3 subdivision 2, practices within the scope of their professional licensure, and has at least 12
- 134.4 hours of training in substance use disorder and treatment;
- 134.5 (3) a clinical trainee who meets the qualifications under section 245I.04, subdivision 6,
- 134.6 practicing under the supervision of a mental health professional who meets the requirements
- 134.7 of clause (2); or
- 134.8 (4) an advanced practice registered nurse as defined in section 148.171, subdivision 3,
- 134.9 who practices within the scope of their professional licensure and has at least 12 hours of
- 134.10 training in substance use disorder and treatment.

134.11 (c) If the comprehensive assessment is not completed within the required time frame,

134.12 the person-centered reason for the delay and the planned completion date must be documented

134.13 in the client's file. The comprehensive assessment is complete upon a qualified staff member's

134.14 dated signature. If the client received a comprehensive assessment that authorized the

134.15 treatment service, ~~an alcohol and drug counselor~~ a staff member qualified under paragraph

134.16 (b) may use the comprehensive assessment for requirements of this subdivision but must

134.17 document a review of the comprehensive assessment and update the comprehensive

134.18 assessment as clinically necessary to ensure compliance with this subdivision within

134.19 applicable timelines. ~~An alcohol and drug counselor~~ A staff member qualified under

134.20 paragraph (b) must sign and date the comprehensive assessment review and update.

134.21 Sec. 22. Minnesota Statutes 2024, section 245G.11, subdivision 7, is amended to read:

134.22 **Subd. 7. Treatment coordination provider qualifications.** (a) Treatment coordination

134.23 must be provided by qualified staff. An individual is qualified to provide treatment

134.24 coordination if the individual meets the qualifications of an alcohol and drug counselor

134.25 under subdivision 5 or if the individual:

- 134.26 (1) is skilled in the process of identifying and assessing a wide range of client needs;
- 134.27 (2) is knowledgeable about local community resources and how to use those resources
- 134.28 for the benefit of the client;
- 134.29 (3) has ~~successfully completed 30 hours of classroom instruction on treatment~~
- 134.30 ~~coordination for an individual with substance use disorder~~ specific training on substance
- 134.31 use disorder and co-occurring disorders that is consistent with national evidence-based
- 134.32 practices; and

135.1 (4) ~~has either~~ meets one of the following criteria:

135.2 (i) has a bachelor's degree in one of the behavioral sciences or related fields and at least  
135.3 1,000 hours of supervised experience working with individuals with substance use disorder;

135.4 ~~or~~

135.5 (ii) has current certification as an alcohol and drug counselor, level I, by the Upper  
135.6 Midwest Indian Council on Addictive Disorders; and or

135.7 (iii) is a mental health practitioner who meets the qualifications under section 245I.04,  
135.8 subdivision 4.

135.9 ~~(5) has at least 2,000 hours of supervised experience working with individuals with~~  
135.10 ~~substance use disorder.~~

135.11 (b) A treatment coordinator must receive at least one hour of supervision regarding  
135.12 individual service delivery from an alcohol and drug counselor, or a mental health  
135.13 professional who has substance use treatment and assessments within the scope of their  
135.14 practice, on a monthly basis.

135.15 Sec. 23. Minnesota Statutes 2024, section 245I.05, subdivision 3, is amended to read:

135.16 Subd. 3. **Initial training.** (a) A staff person must receive training about:

135.17 (1) vulnerable adult maltreatment under section 245A.65, subdivision 3; and

135.18 (2) the maltreatment of minor reporting requirements and definitions in chapter 260E  
135.19 within 72 hours of first providing direct contact services to a client.

135.20 (b) Before providing direct contact services to a client, a staff person must receive training  
135.21 about:

135.22 (1) client rights and protections under section 245I.12;

135.23 (2) the Minnesota Health Records Act, including client confidentiality, family engagement  
135.24 under section 144.294, and client privacy;

135.25 (3) emergency procedures that the staff person must follow when responding to a fire,  
135.26 inclement weather, a report of a missing person, and a behavioral or medical emergency;

135.27 (4) specific activities and job functions for which the staff person is responsible, including  
135.28 the license holder's program policies and procedures applicable to the staff person's position;

135.29 (5) professional boundaries that the staff person must maintain; and

136.1 (6) specific needs of each client to whom the staff person will be providing direct contact  
136.2 services, including each client's developmental status, cognitive functioning, and physical  
136.3 and mental abilities.

136.4 (c) Before providing direct contact services to a client, a mental health rehabilitation  
136.5 worker, mental health behavioral aide, or mental health practitioner required to receive the  
136.6 training according to section 245I.04, subdivision 4, must receive 30 hours of training about:

136.7 (1) mental illnesses;

136.8 (2) client recovery and resiliency;

136.9 (3) mental health de-escalation techniques;

136.10 (4) co-occurring mental illness and substance use disorders; and

136.11 (5) psychotropic medications and medication side effects, including tardive dyskinesia.

136.12 (d) Within 90 days of first providing direct contact services to an adult client, mental  
136.13 health practitioner, mental health certified peer specialist, or mental health rehabilitation  
136.14 worker must receive training about:

136.15 (1) trauma-informed care and secondary trauma;

136.16 (2) person-centered individual treatment plans, including seeking partnerships with  
136.17 family and other natural supports;

136.18 (3) co-occurring substance use disorders; and

136.19 (4) culturally responsive treatment practices.

136.20 (e) Within 90 days of first providing direct contact services to a child client, mental  
136.21 health practitioner, mental health certified family peer specialist, mental health certified  
136.22 peer specialist, or mental health behavioral aide must receive training about the topics in  
136.23 clauses (1) to (5). This training must address the developmental characteristics of each child  
136.24 served by the license holder and address the needs of each child in the context of the child's  
136.25 family, support system, and culture. Training topics must include:

136.26 (1) trauma-informed care and secondary trauma, including adverse childhood experiences  
136.27 (ACEs);

136.28 (2) family-centered treatment plan development, including seeking partnership with a  
136.29 child client's family and other natural supports;

136.30 (3) mental illness and co-occurring substance use disorders in family systems;

136.31 (4) culturally responsive treatment practices; and

137.1 (5) child development, including cognitive functioning, and physical and mental abilities.

137.2 (f) For a mental health behavioral aide, the training under paragraph (e) must include  
137.3 parent team training using a curriculum approved by the commissioner.

137.4 Sec. 24. Minnesota Statutes 2024, section 245I.05, subdivision 5, is amended to read:

137.5 Subd. 5. **Additional training for medication administration.** (a) Prior to administering  
137.6 medications to a client under delegated authority or observing a client self-administer  
137.7 medications, a staff person who is not a licensed prescriber, registered nurse, or licensed  
137.8 practical nurse qualified under section 148.171, subdivision 8, must receive training about  
137.9 psychotropic medications, side effects including tardive dyskinesia, and medication  
137.10 management.

137.11 (b) Prior to administering medications to a client under delegated authority, a staff person  
137.12 must successfully complete a:

137.13 (1) medication administration training program for unlicensed personnel through an  
137.14 accredited Minnesota postsecondary educational institution with completion of the course  
137.15 documented in writing and placed in the staff person's personnel file; or

137.16 (2) formalized training program taught by a registered nurse or licensed prescriber that  
137.17 is offered by the license holder. A staff person's successful completion of the formalized  
137.18 training program must include direct observation of the staff person to determine the staff  
137.19 person's areas of competency.

137.20 Sec. 25. Minnesota Statutes 2024, section 245I.06, subdivision 3, is amended to read:

137.21 Subd. 3. **Treatment supervision and direct observation of mental health**  
137.22 **rehabilitation workers and mental health behavioral aides.** (a) A mental health behavioral  
137.23 aide or a mental health rehabilitation worker must receive direct observation from a mental  
137.24 health professional, clinical trainee, certified rehabilitation specialist, or mental health  
137.25 practitioner while the mental health behavioral aide or mental health rehabilitation worker  
137.26 provides treatment services to clients, no less than twice per month for the first six months  
137.27 of employment and once per month thereafter. The staff person performing the direct  
137.28 observation must approve of the progress note ~~for the observed treatment service~~ twice per  
137.29 month for first six months of employment, and as needed and identified in a supervision  
137.30 plan thereafter. Approval may be given through an attestation that is stored in the employee  
137.31 file.

138.1 (b) For a mental health rehabilitation worker qualified under section 245I.04, subdivision  
138.2 14, paragraph (a), clause (2), item (i), treatment supervision in the first 2,000 hours of work  
138.3 must at a minimum consist of:

138.4 (1) monthly individual supervision; and

138.5 (2) direct observation twice per month.

138.6 Sec. 26. Minnesota Statutes 2024, section 245I.11, subdivision 5, is amended to read:

138.7 Subd. 5. **Medication administration in residential programs.** If a license holder is  
138.8 licensed as a residential program, the license holder must:

138.9 (1) assess and document each client's ability to self-administer medication. In the  
138.10 assessment, the license holder must evaluate the client's ability to: (i) comply with prescribed  
138.11 medication regimens; and (ii) store the client's medications safely and in a manner that  
138.12 protects other individuals in the facility. Through the assessment process, the license holder  
138.13 must assist the client in developing the skills necessary to safely self-administer medication;

138.14 (2) monitor the effectiveness of medications, side effects of medications, and adverse  
138.15 reactions to medications, including symptoms and signs of tardive dyskinesia, for each  
138.16 client. The license holder must address and document any concerns about a client's  
138.17 medications;

138.18 (3) ensure that no staff person or client gives a legend drug supply for one client to  
138.19 another client;

138.20 (4) have policies and procedures for: (i) keeping a record of each client's medication  
138.21 orders; (ii) keeping a record of any incident of deferring a client's medications; (iii)  
138.22 documenting any incident when a client's medication is omitted; and (iv) documenting when  
138.23 a client refuses to take medications as prescribed; and

138.24 (5) document and track medication errors, document whether the license holder notified  
138.25 anyone about the medication error, determine if the license holder must take any follow-up  
138.26 actions, and identify the staff persons who are responsible for taking follow-up actions.

138.27 Sec. 27. Minnesota Statutes 2024, section 245I.12, subdivision 5, is amended to read:

138.28 Subd. 5. **Client grievances.** (a) The license holder must have a grievance procedure  
138.29 that:

138.30 (1) describes to clients how the license holder will meet the requirements in this  
138.31 subdivision; and

139.1 (2) contains the current public contact information of the Department of Human Services,  
139.2 Licensing Division; the Office of Ombudsman for Mental Health and Developmental  
139.3 Disabilities; the Department of Health, Office of Health Facilities Complaints; and all  
139.4 applicable health-related licensing boards.

139.5 (b) On the day of each client's admission, the license holder must explain the grievance  
139.6 procedure to the client.

139.7 (c) The license holder must:

139.8 (1) post the grievance procedure in a place visible to clients and provide a copy of the  
139.9 grievance procedure upon request;

139.10 (2) allow clients, former clients, and their authorized representatives to submit a grievance  
139.11 to the license holder;

139.12 (3) within three business days of receiving a client's grievance, acknowledge in writing  
139.13 that the license holder received the client's grievance. If applicable, the license holder must  
139.14 include a notice of the client's separate appeal rights for a managed care organization's  
139.15 reduction, termination, or denial of a covered service;

139.16 (4) within 15 business days of receiving a client's grievance, provide a written final  
139.17 response to the client's grievance containing the license holder's official response to the  
139.18 grievance; and

139.19 (5) allow the client to bring a grievance to the person with the highest level of authority  
139.20 in the program.

139.21 (d) Clients may voice grievances and recommend changes in policies and services to  
139.22 staff and others of their choice, free from restraint, interference, coercion, discrimination,  
139.23 or reprisal, including threat of discharge.

139.24 Sec. 28. Minnesota Statutes 2024, section 254B.05, subdivision 1, is amended to read:

139.25 Subdivision 1. **Licensure or certification required.** (a) Programs licensed by the  
139.26 commissioner are eligible vendors. Hospitals may apply for and receive licenses to be  
139.27 eligible vendors, notwithstanding the provisions of section 245A.03. American Indian  
139.28 programs that provide substance use disorder treatment, extended care, transitional residence,  
139.29 or outpatient treatment services, and are licensed by tribal government are eligible vendors.

139.30 (b) A licensed professional in private practice as defined in section 245G.01, subdivision  
139.31 17, who meets the requirements of section 245G.11, subdivisions 1 and 4, is an eligible  
139.32 vendor of a comprehensive assessment provided according to section 254A.19, subdivision

140.1 3, and treatment services provided according to sections 245G.06 and 245G.07, subdivision  
140.2 1, paragraphs (a), clauses (1) to (5), and (b); and subdivision 2, clauses (1) to (6).

140.3 (c) A county is an eligible vendor for a comprehensive assessment when provided by  
140.4 an individual who meets the staffing credentials of section 245G.11, subdivisions 1 and 5,  
140.5 and completed according to the requirements of section 254A.19, subdivision 3. A county  
140.6 is an eligible vendor of care coordination services when provided by an individual who  
140.7 meets the staffing credentials of section 245G.11, subdivisions 1 and 7, and provided  
140.8 according to the requirements of section 245G.07, subdivision 1, paragraph (a), clause (5).  
140.9 A county is an eligible vendor of peer recovery services when the services are provided by  
140.10 an individual who meets the requirements of section 245G.11, subdivision 8.

140.11 (d) A recovery community organization that meets the requirements of clauses (1) to  
140.12 (14) and meets certification ~~or accreditation~~ requirements of the ~~Alliance for Recovery~~  
140.13 ~~Centered Organizations, the Council on Accreditation of Peer Recovery Support Services,~~  
140.14 ~~or a Minnesota statewide recovery organization identified by the commissioner~~ Minnesota  
140.15 Alliance of Recovery Community Organizations is an eligible vendor of peer recovery  
140.16 support services. ~~A Minnesota statewide recovery organization identified by the~~  
140.17 ~~commissioner must update recovery community organization applicants for certification or~~  
140.18 ~~accreditation on the status of the application within 45 days of receipt. If the approved~~  
140.19 ~~statewide recovery organization denies an application, it must provide a written explanation~~  
140.20 ~~for the denial to the recovery community organization.~~ Eligible vendors under this paragraph  
140.21 must:

140.22 (1) be nonprofit organizations under section 501(c)(3) of the Internal Revenue Code, be  
140.23 free from conflicting self-interests, and be autonomous in decision-making, program  
140.24 development, peer recovery support services provided, and advocacy efforts for the purpose  
140.25 of supporting the recovery community organization's mission;

140.26 (2) be led and governed by individuals in the recovery community, with more than 50  
140.27 percent of the board of directors or advisory board members self-identifying as people in  
140.28 personal recovery from substance use disorders;

140.29 (3) have a mission statement and conduct corresponding activities indicating that the  
140.30 organization's primary purpose is to support recovery from substance use disorder;

140.31 (4) demonstrate ongoing community engagement with the identified primary region and  
140.32 population served by the organization, including individuals in recovery and their families,  
140.33 friends, and recovery allies;

141.1 (5) be accountable to the recovery community through documented priority-setting and  
141.2 participatory decision-making processes that promote the engagement of, and consultation  
141.3 with, people in recovery and their families, friends, and recovery allies;

141.4 (6) provide nonclinical peer recovery support services, including but not limited to  
141.5 recovery support groups, recovery coaching, telephone recovery support, skill-building,  
141.6 and harm-reduction activities, and provide recovery public education and advocacy;

141.7 (7) have written policies that allow for and support opportunities for all paths toward  
141.8 recovery and refrain from excluding anyone based on their chosen recovery path, which  
141.9 may include but is not limited to harm reduction paths, faith-based paths, and nonfaith-based  
141.10 paths;

141.11 (8) maintain organizational practices to meet the needs of Black, Indigenous, and people  
141.12 of color communities, LGBTQ+ communities, and other underrepresented or marginalized  
141.13 communities. Organizational practices may include board and staff training, service offerings,  
141.14 advocacy efforts, and culturally informed outreach and services;

141.15 (9) use recovery-friendly language in all media and written materials that is supportive  
141.16 of and promotes recovery across diverse geographical and cultural contexts and reduces  
141.17 stigma;

141.18 (10) establish and maintain a publicly available recovery community organization code  
141.19 of ethics and grievance policy and procedures;

141.20 (11) not classify or treat any recovery peer hired on or after July 1, 2024, as an  
141.21 independent contractor;

141.22 (12) not classify or treat any recovery peer as an independent contractor on or after  
141.23 January 1, 2025;

141.24 (13) provide an orientation for recovery peers that includes an overview of the consumer  
141.25 advocacy services provided by the Ombudsman for Mental Health and Developmental  
141.26 Disabilities and other relevant advocacy services; ~~and~~

141.27 (14) provide notice to peer recovery support services participants that includes the  
141.28 following statement: "If you have a complaint about the provider or the person providing  
141.29 your peer recovery support services, you may contact the Minnesota Alliance of Recovery  
141.30 Community Organizations. You may also contact the Office of Ombudsman for Mental  
141.31 Health and Developmental Disabilities." The statement must also include:

142.1 (i) the telephone number, website address, email address, and mailing address of the  
142.2 Minnesota Alliance of Recovery Community Organizations and the Office of Ombudsman  
142.3 for Mental Health and Developmental Disabilities;

142.4 (ii) the recovery community organization's name, address, email, telephone number, and  
142.5 name or title of the person at the recovery community organization to whom problems or  
142.6 complaints may be directed; and

142.7 (iii) a statement that the recovery community organization will not retaliate against a  
142.8 peer recovery support services participant because of a complaint; and

142.9 (15) comply with the requirements of section 245A.04, subdivision 15a.

142.10 (e) A recovery community organization approved by the commissioner before June 30,  
142.11 2023, must have begun the application process as required by an approved certifying or  
142.12 accrediting entity and have begun the process to meet the requirements under paragraph (d)  
142.13 by September 1, 2024, in order to be considered as an eligible vendor of peer recovery  
142.14 support services.

142.15 (f) A recovery community organization that is aggrieved by ~~an accreditation, a~~  
142.16 ~~certification, or membership~~ determination and believes it meets the requirements under  
142.17 paragraph (d) may appeal the determination under section 256.045, subdivision 3, paragraph  
142.18 (a), clause (14), for reconsideration as an eligible vendor. If the human services judge  
142.19 determines that the recovery community organization meets the requirements under paragraph  
142.20 (d), the recovery community organization is an eligible vendor of peer recovery support  
142.21 services for up to two years from the date of the determination. After two years, the recovery  
142.22 community organization must apply for certification under paragraph (d) to continue to be  
142.23 an eligible vendor of peer recovery support services.

142.24 (g) All recovery community organizations must be certified ~~or accredited~~ by an entity  
142.25 listed in paragraph (d) by June 30, 2025.

142.26 (h) Detoxification programs licensed under Minnesota Rules, parts 9530.6510 to  
142.27 9530.6590, are not eligible vendors. Programs that are not licensed as a residential or  
142.28 nonresidential substance use disorder treatment or withdrawal management program by the  
142.29 commissioner or by tribal government or do not meet the requirements of subdivisions 1a  
142.30 and 1b are not eligible vendors.

142.31 (i) Hospitals, federally qualified health centers, and rural health clinics are eligible  
142.32 vendors of a comprehensive assessment when the comprehensive assessment is completed  
142.33 according to section 254A.19, subdivision 3, and by an individual who meets the criteria

143.1 of an alcohol and drug counselor according to section 245G.11, subdivision 5. The alcohol  
143.2 and drug counselor must be individually enrolled with the commissioner and reported on  
143.3 the claim as the individual who provided the service.

143.4 (j) Any complaints about a recovery community organization or peer recovery support  
143.5 services may be made to and reviewed or investigated by the ombudsperson for behavioral  
143.6 health and developmental disabilities under sections 245.91 and 245.94.

143.7 Sec. 29. Minnesota Statutes 2024, section 254B.05, subdivision 5, is amended to read:

143.8 Subd. 5. **Rate requirements.** (a) The commissioner shall establish rates for substance  
143.9 use disorder services and service enhancements funded under this chapter.

143.10 (b) Eligible substance use disorder treatment services include:

143.11 (1) those licensed, as applicable, according to chapter 245G or applicable Tribal license  
143.12 and provided according to the following ASAM levels of care:

143.13 (i) ASAM level 0.5 early intervention services provided according to section 254B.19,  
143.14 subdivision 1, clause (1);

143.15 (ii) ASAM level 1.0 outpatient services provided according to section 254B.19,  
143.16 subdivision 1, clause (2);

143.17 (iii) ASAM level 2.1 intensive outpatient services provided according to section 254B.19,  
143.18 subdivision 1, clause (3);

143.19 (iv) ASAM level 2.5 partial hospitalization services provided according to section  
143.20 254B.19, subdivision 1, clause (4);

143.21 (v) ASAM level 3.1 clinically managed low-intensity residential services provided  
143.22 according to section 254B.19, subdivision 1, clause (5). The commissioner shall use the  
143.23 base payment rate of \$79.84 per day for services provided under this item;

143.24 (vi) ASAM level 3.1 clinically managed low-intensity residential services provided  
143.25 according to section 254B.19, subdivision 1, clause (5), at 15 or more hours of skilled  
143.26 treatment services each week. The commissioner shall use the base payment rate of \$166.13  
143.27 per day for services provided under this item;

143.28 (vii) ASAM level 3.3 clinically managed population-specific high-intensity residential  
143.29 services provided according to section 254B.19, subdivision 1, clause (6). The commissioner  
143.30 shall use the specified base payment rate of \$224.06 per day for services provided under  
143.31 this item; and

- 144.1 (viii) ASAM level 3.5 clinically managed high-intensity residential services provided  
144.2 according to section 254B.19, subdivision 1, clause (7). The commissioner shall use the  
144.3 specified base payment rate of \$224.06 per day for services provided under this item;
- 144.4 (2) comprehensive assessments provided according to section 254A.19, subdivision 3;
- 144.5 (3) treatment coordination services provided according to section 245G.07, subdivision  
144.6 1, paragraph (a), clause (5);
- 144.7 (4) peer recovery support services provided according to section 245G.07, subdivision  
144.8 2, clause (8);
- 144.9 (5) withdrawal management services provided according to chapter 245F;
- 144.10 (6) hospital-based treatment services that are licensed according to sections 245G.01 to  
144.11 245G.17 or applicable Tribal license and licensed as a hospital under sections 144.50 to  
144.12 144.56;
- 144.13 (7) substance use disorder treatment services with medications for opioid use disorder  
144.14 provided in an opioid treatment program licensed according to sections 245G.01 to 245G.17  
144.15 and 245G.22, or under an applicable Tribal license;
- 144.16 (8) medium-intensity residential treatment services that provide 15 hours of skilled  
144.17 treatment services each week and are licensed according to sections 245G.01 to 245G.17  
144.18 and 245G.21 or applicable Tribal license;
- 144.19 (9) adolescent treatment programs that are licensed as outpatient treatment programs  
144.20 according to sections 245G.01 to 245G.18 or as residential treatment programs according  
144.21 to Minnesota Rules, parts 2960.0010 to 2960.0220, and 2960.0430 to 2960.0490, or  
144.22 applicable Tribal license;
- 144.23 (10) ASAM 3.5 clinically managed high-intensity residential services that are licensed  
144.24 according to sections 245G.01 to 245G.17 and 245G.21 or applicable Tribal license, which  
144.25 provide ASAM level of care 3.5 according to section 254B.19, subdivision 1, clause (7),  
144.26 and are provided by a state-operated vendor or to clients who have been civilly committed  
144.27 to the commissioner, present the most complex and difficult care needs, and are a potential  
144.28 threat to the community; and
- 144.29 (11) room and board facilities that meet the requirements of subdivision 1a.
- 144.30 (c) The commissioner shall establish higher rates for programs that meet the requirements  
144.31 of paragraph (b) and one of the following additional requirements:
- 144.32 (1) programs that serve parents with their children if the program:

- 145.1 (i) provides on-site child care during the hours of treatment activity that:
- 145.2 (A) is licensed under chapter 245A as a child care center under Minnesota Rules, chapter
- 145.3 9503; or
- 145.4 (B) is licensed under chapter 245A and sections 245G.01 to 245G.19; or
- 145.5 (ii) arranges for off-site child care during hours of treatment activity at a facility that is
- 145.6 licensed under chapter 245A as:
- 145.7 (A) a child care center under Minnesota Rules, chapter 9503; or
- 145.8 (B) a family child care home under Minnesota Rules, chapter 9502;
- 145.9 (2) culturally specific or culturally responsive programs as defined in section 254B.01,
- 145.10 subdivision 4a;
- 145.11 (3) disability responsive programs as defined in section 254B.01, subdivision 4b;
- 145.12 (4) programs that offer medical services delivered by appropriately credentialed health
- 145.13 care staff in an amount equal to one hour per client per week if the medical needs of the
- 145.14 client and the nature and provision of any medical services provided are documented in the
- 145.15 client file; or
- 145.16 (5) programs that offer services to individuals with co-occurring mental health and
- 145.17 substance use disorder problems if:
- 145.18 (i) the program meets the co-occurring requirements in section 245G.20;
- 145.19 (ii) the program employs a mental health professional as defined in section 245I.04,
- 145.20 subdivision 2;
- 145.21 (iii) clients scoring positive on a standardized mental health screen receive a mental
- 145.22 health diagnostic assessment within ten days of admission, excluding weekends and holidays;
- 145.23 (iv) the program has standards for multidisciplinary case review that include a monthly
- 145.24 review for each client that, at a minimum, includes a licensed mental health professional
- 145.25 and licensed alcohol and drug counselor, and their involvement in the review is documented;
- 145.26 (v) family education is offered that addresses mental health and substance use disorder
- 145.27 and the interaction between the two; and
- 145.28 (vi) co-occurring counseling staff shall receive eight hours of co-occurring disorder
- 145.29 training annually.
- 145.30 (d) In order to be eligible for a higher rate under paragraph (c), clause (1), a program
- 145.31 that provides arrangements for off-site child care must maintain current documentation at

146.1 the substance use disorder facility of the child care provider's current licensure to provide  
146.2 child care services.

146.3 (e) Adolescent residential programs that meet the requirements of Minnesota Rules,  
146.4 parts 2960.0430 to 2960.0490 and 2960.0580 to 2960.0690, are exempt from the requirements  
146.5 in paragraph (c), clause (5), items (i) to (iv).

146.6 (f) Substance use disorder services that are otherwise covered as direct face-to-face  
146.7 services may be provided via telehealth as defined in section 256B.0625, subdivision 3b.  
146.8 The use of telehealth to deliver services must be medically appropriate to the condition and  
146.9 needs of the person being served. Reimbursement shall be at the same rates and under the  
146.10 same conditions that would otherwise apply to direct face-to-face services.

146.11 (g) For the purpose of reimbursement under this section, substance use disorder treatment  
146.12 services provided in a group setting without a group participant maximum or maximum  
146.13 client to staff ratio under chapter 245G shall not exceed a client to staff ratio of 48 to one.  
146.14 At least one of the attending staff must meet the qualifications as established under this  
146.15 chapter for the type of treatment service provided. A recovery peer may not be included as  
146.16 part of the staff ratio.

146.17 (h) Payment for outpatient substance use disorder services that are licensed according  
146.18 to sections 245G.01 to 245G.17 is limited to six hours per day or 30 hours per week unless  
146.19 prior authorization of a greater number of hours is obtained from the commissioner.

146.20 (i) Payment for substance use disorder services under this section must start from the  
146.21 day of service initiation, when the comprehensive assessment is completed within the  
146.22 required timelines.

146.23 (j) A license holder that is unable to provide all residential treatment services because  
146.24 a client missed services remains eligible to bill for the client's intensity level of services  
146.25 under this paragraph if the license holder can document the reason the client missed services  
146.26 and the interventions done to address the client's absence.

146.27 (k) Hours in a treatment week may be reduced in observance of federally recognized  
146.28 holidays.

146.29 (l) Eligible vendors of peer recovery support services must:

146.30 (1) submit to a review by the commissioner of up to ten percent of all medical assistance  
146.31 and behavioral health fund claims to determine the medical necessity of peer recovery  
146.32 support services for entities billing for peer recovery support services individually and not  
146.33 receiving a daily rate; and

147.1 (2) limit an individual client to 14 hours per week for peer recovery support services  
147.2 from an individual provider of peer recovery support services.

147.3 (m) Peer recovery support services not provided in accordance with section 254B.052  
147.4 are subject to monetary recovery under section 256B.064 as money improperly paid.

147.5 Sec. 30. Minnesota Statutes 2024, section 256B.0615, subdivision 4, is amended to read:

147.6 Subd. 4. **Peer support specialist program providers.** The commissioner shall develop  
147.7 a process to certify peer support specialist programs, in accordance with the federal  
147.8 guidelines, in order for the program to bill for reimbursable services. Peer support programs  
147.9 may be freestanding or within existing mental health community provider centers and  
147.10 services.

147.11 Sec. 31. Minnesota Statutes 2024, section 256B.0616, subdivision 4, is amended to read:

147.12 Subd. 4. **Family peer support specialist program providers.** The commissioner shall  
147.13 develop a process to certify family peer support ~~specialist~~ programs, in accordance with the  
147.14 federal guidelines, in order for the program to bill for reimbursable services. Family peer  
147.15 support programs must operate within an existing mental health community provider or  
147.16 center.

147.17 Sec. 32. Minnesota Statutes 2024, section 256B.0616, subdivision 5, is amended to read:

147.18 Subd. 5. **Certified family peer specialist training and certification.** (a) The  
147.19 commissioner shall develop a or approve the use of an existing training and certification  
147.20 process for certified certifying family peer specialists. The Family peer specialist candidates  
147.21 must have raised or be currently raising a child with a mental illness; ~~have had~~ experience  
147.22 navigating the children's mental health system; ~~and must~~ demonstrate leadership and  
147.23 advocacy skills and a strong dedication to family-driven and family-focused services. The  
147.24 training curriculum must teach participating family peer ~~specialists~~ specialist candidates  
147.25 specific skills relevant to providing peer support to other parents and youth.

147.26 (b) In addition to initial training and certification, the commissioner shall develop ongoing  
147.27 continuing educational workshops on pertinent issues related to family peer support  
147.28 counseling.

147.29 (c) Initial training leading to certification as a family peer specialist and continuing  
147.30 education for certified family peer specialists must be delivered by the commissioner or a  
147.31 third-party organization approved by the commissioner. An approved third-party organization  
147.32 may also provide continuing education of certified family peer specialists.

148.1 Sec. 33. Minnesota Statutes 2024, section 256B.0622, subdivision 3a, is amended to read:

148.2 Subd. 3a. **Provider certification and contract requirements for assertive community**  
148.3 **treatment.** (a) The assertive community treatment provider must have each ACT team be  
148.4 certified by the state following the certification process and procedures developed by the  
148.5 commissioner. The certification process determines whether the ACT team meets the  
148.6 standards for assertive community treatment under this section, the standards in chapter  
148.7 245I as required in section 245I.011, subdivision 5, and minimum program fidelity standards  
148.8 as measured by a nationally recognized fidelity tool approved by the commissioner.  
148.9 Recertification must occur at least every three years.

148.10 (b) An ACT team certified under this subdivision must meet the following standards:

148.11 (1) have capacity to recruit, hire, manage, and train required ACT team members;

148.12 (2) have adequate administrative ability to ensure availability of services;

148.13 (3) ensure flexibility in service delivery to respond to the changing and intermittent care  
148.14 needs of a client as identified by the client and the individual treatment plan;

148.15 (4) keep all necessary records required by law;

148.16 (5) be an enrolled Medicaid provider; ~~and~~

148.17 (6) establish and maintain a quality assurance plan to determine specific service outcomes  
148.18 and the client's satisfaction with services; and

148.19 (7) ensure that overall treatment supervision to the ACT team is provided by a qualified  
148.20 member of the ACT team, and is available during and after regular business hours and on  
148.21 weekends and holidays.

148.22 (c) The commissioner may intervene at any time and decertify an ACT team with cause.  
148.23 The commissioner shall establish a process for decertification of an ACT team and shall  
148.24 require corrective action, medical assistance repayment, or decertification of an ACT team  
148.25 that no longer meets the requirements in this section or that fails to meet the clinical quality  
148.26 standards or administrative standards provided by the commissioner in the application and  
148.27 certification process. The decertification is subject to appeal to the state.

148.28 Sec. 34. Minnesota Statutes 2024, section 256B.0622, subdivision 7a, is amended to read:

148.29 Subd. 7a. **Assertive community treatment team staff requirements and roles.** (a)

148.30 The required treatment staff qualifications and roles for an ACT team are:

148.31 (1) the team leader:

149.1 (i) shall be a mental health professional. ~~Individuals who are not licensed but who are~~  
149.2 ~~eligible for licensure and are otherwise qualified may also fulfill this role;~~ clinical trainee,  
149.3 or mental health practitioner;

149.4 (ii) must be an active member of the ACT team and provide some direct services to  
149.5 clients;

149.6 (iii) must be a single full-time staff member, dedicated to the ACT team, who is  
149.7 responsible for overseeing the administrative operations of the team and supervising team  
149.8 members to ensure delivery of best and ethical practices; and

149.9 (iv) must be available to ensure that overall treatment supervision to the ACT team is  
149.10 available after regular business hours and on weekends and holidays and is provided by a  
149.11 qualified member of the ACT team;

149.12 (2) the psychiatric care provider:

149.13 (i) must be a mental health professional permitted to prescribe psychiatric medications  
149.14 as part of the mental health professional's scope of practice. The psychiatric care provider  
149.15 must have demonstrated clinical experience working with individuals with serious and  
149.16 persistent mental illness;

149.17 (ii) shall collaborate with the team leader in sharing overall clinical responsibility for  
149.18 screening and admitting clients; monitoring clients' treatment and team member service  
149.19 delivery; educating staff on psychiatric and nonpsychiatric medications, their side effects,  
149.20 and health-related conditions; actively collaborating with nurses; and helping provide  
149.21 treatment supervision to the team;

149.22 (iii) shall fulfill the following functions for assertive community treatment clients:  
149.23 provide assessment and treatment of clients' symptoms and response to medications, including  
149.24 side effects; provide brief therapy to clients; provide diagnostic and medication education  
149.25 to clients, with medication decisions based on shared decision making; monitor clients'  
149.26 nonpsychiatric medical conditions and nonpsychiatric medications; and conduct home and  
149.27 community visits;

149.28 (iv) shall serve as the point of contact for psychiatric treatment if a client is hospitalized  
149.29 for mental health treatment and shall communicate directly with the client's inpatient  
149.30 psychiatric care providers to ensure continuity of care;

149.31 (v) shall have a minimum full-time equivalency that is prorated at a rate of 16 hours per  
149.32 50 clients. Part-time psychiatric care providers shall have designated hours to work on the  
149.33 team, with sufficient blocks of time on consistent days to carry out the provider's clinical,

150.1 supervisory, and administrative responsibilities. No more than two psychiatric care providers  
150.2 may share this role; and

150.3 (vi) shall provide psychiatric backup to the program after regular business hours and on  
150.4 weekends and holidays. The psychiatric care provider may delegate this duty to another  
150.5 qualified psychiatric provider;

150.6 (3) the nursing staff:

150.7 (i) shall consist of one to three registered nurses or advanced practice registered nurses,  
150.8 of whom at least one has a minimum of one-year experience working with adults with  
150.9 serious mental illness and a working knowledge of psychiatric medications. No more than  
150.10 two individuals can share a full-time equivalent position;

150.11 (ii) are responsible for managing medication, administering and documenting medication  
150.12 treatment, and managing a secure medication room; and

150.13 (iii) shall develop strategies, in collaboration with clients, to maximize taking medications  
150.14 as prescribed; screen and monitor clients' mental and physical health conditions and  
150.15 medication side effects; engage in health promotion, prevention, and education activities;  
150.16 communicate and coordinate services with other medical providers; facilitate the development  
150.17 of the individual treatment plan for clients assigned; and educate the ACT team in monitoring  
150.18 psychiatric and physical health symptoms and medication side effects;

150.19 (4) the co-occurring disorder specialist:

150.20 (i) shall be a full-time equivalent co-occurring disorder specialist who has received  
150.21 specific training on co-occurring disorders that is consistent with national evidence-based  
150.22 practices. The training must include practical knowledge of common substances and how  
150.23 they affect mental illnesses, the ability to assess substance use disorders and the client's  
150.24 stage of treatment, motivational interviewing, and skills necessary to provide counseling to  
150.25 clients at all different stages of change and treatment. The co-occurring disorder specialist  
150.26 may also be an individual who is a licensed alcohol and drug counselor as described in  
150.27 section 148F.01, subdivision 5, or a counselor who otherwise meets the training, experience,  
150.28 and other requirements in section 245G.11, subdivision 5. No more than two co-occurring  
150.29 disorder specialists may occupy this role; and

150.30 (ii) shall provide or facilitate the provision of co-occurring disorder treatment to clients.  
150.31 The co-occurring disorder specialist shall serve as a consultant and educator to fellow ACT  
150.32 team members on co-occurring disorders;

150.33 (5) the vocational specialist:

151.1 (i) shall be a full-time vocational specialist who has at least one-year experience providing  
151.2 employment services or advanced education that involved field training in vocational services  
151.3 to individuals with mental illness. An individual who does not meet these qualifications  
151.4 may also serve as the vocational specialist upon completing a training plan approved by the  
151.5 commissioner;

151.6 (ii) shall provide or facilitate the provision of vocational services to clients. The vocational  
151.7 specialist serves as a consultant and educator to fellow ACT team members on these services;  
151.8 and

151.9 (iii) must not refer individuals to receive any type of vocational services or linkage by  
151.10 providers outside of the ACT team;

151.11 (6) the mental health certified peer specialist:

151.12 (i) shall be a full-time equivalent. No more than two individuals can share this position.  
151.13 The mental health certified peer specialist is a fully integrated team member who provides  
151.14 highly individualized services in the community and promotes the self-determination and  
151.15 shared decision-making abilities of clients. This requirement may be waived due to workforce  
151.16 shortages upon approval of the commissioner;

151.17 (ii) must provide coaching, mentoring, and consultation to the clients to promote recovery,  
151.18 self-advocacy, and self-direction, promote wellness management strategies, and assist clients  
151.19 in developing advance directives; and

151.20 (iii) must model recovery values, attitudes, beliefs, and personal action to encourage  
151.21 wellness and resilience, provide consultation to team members, promote a culture where  
151.22 the clients' points of view and preferences are recognized, understood, respected, and  
151.23 integrated into treatment, and serve in a manner equivalent to other team members;

151.24 (7) the program administrative assistant shall be a full-time office-based program  
151.25 administrative assistant position assigned to solely work with the ACT team, providing a  
151.26 range of supports to the team, clients, and families; and

151.27 (8) additional staff:

151.28 (i) shall be based on team size. Additional treatment team staff may include mental  
151.29 health professionals; clinical trainees; certified rehabilitation specialists; mental health  
151.30 practitioners; or mental health rehabilitation workers. These individuals shall have the  
151.31 knowledge, skills, and abilities required by the population served to carry out rehabilitation  
151.32 and support functions; and

151.33 (ii) shall be selected based on specific program needs or the population served.

152.1 (b) Each ACT team must clearly document schedules for all ACT team members.

152.2 (c) Each ACT team member must serve as a primary team member for clients assigned  
152.3 by the team leader and are responsible for facilitating the individual treatment plan process  
152.4 for those clients. The primary team member for a client is the responsible team member  
152.5 knowledgeable about the client's life and circumstances and writes the individual treatment  
152.6 plan. The primary team member provides individual supportive therapy or counseling, and  
152.7 provides primary support and education to the client's family and support system.

152.8 (d) Members of the ACT team must have strong clinical skills, professional qualifications,  
152.9 experience, and competency to provide a full breadth of rehabilitation services. Each staff  
152.10 member shall be proficient in their respective discipline and be able to work collaboratively  
152.11 as a member of a multidisciplinary team to deliver the majority of the treatment,  
152.12 rehabilitation, and support services clients require to fully benefit from receiving assertive  
152.13 community treatment.

152.14 (e) Each ACT team member must fulfill training requirements established by the  
152.15 commissioner.

152.16 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
152.17 of human services shall notify the revisor of statutes when federal approval is obtained.

152.18 Sec. 35. Minnesota Statutes 2024, section 256B.0625, subdivision 20, is amended to read:

152.19 Subd. 20. **Mental health case management.** (a) To the extent authorized by rule of the  
152.20 state agency, medical assistance covers case management services to persons with serious  
152.21 and persistent mental illness, persons with a complex post-traumatic stress disorder, and  
152.22 children with severe emotional disturbance. Services provided under this section must meet  
152.23 the relevant standards in sections 245.461 to 245.4887, the Comprehensive Adult and  
152.24 Children's Mental Health Acts, Minnesota Rules, parts 9520.0900 to 9520.0926, and  
152.25 9505.0322, excluding subpart 10.

152.26 (b) Entities meeting program standards set out in rules governing family community  
152.27 support services as defined in section 245.4871, subdivision 17, are eligible for medical  
152.28 assistance reimbursement for case management services for children with severe emotional  
152.29 disturbance when these services meet the program standards in Minnesota Rules, parts  
152.30 9520.0900 to 9520.0926 and 9505.0322, excluding subparts 6 and 10.

152.31 (c) Medical assistance and MinnesotaCare payment for mental health case management  
152.32 shall be made on a monthly basis. In order to receive payment for an eligible child, the  
152.33 provider must document at least a face-to-face contact either in person or by interactive

153.1 video that meets the requirements of subdivision 20b with the child, the child's parents, or  
153.2 the child's legal representative. To receive payment for an eligible adult, the provider must  
153.3 document:

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

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

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

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

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

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

153.33 (h) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for  
153.34 mental health case management shall be provided by the recipient's county of responsibility,

154.1 as defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds  
154.2 used to match other federal funds. If the service is provided by a tribal agency, the nonfederal  
154.3 share, if any, shall be provided by the recipient's tribe. When this service is paid by the state  
154.4 without a federal share through fee-for-service, 50 percent of the cost shall be provided by  
154.5 the recipient's county of responsibility.

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

154.10 (j) The commissioner may suspend, reduce, or terminate the reimbursement to a provider  
154.11 that does not meet the reporting or other requirements of this section. The county of  
154.12 responsibility, as defined in sections 256G.01 to 256G.12, or, if applicable, the tribal agency,  
154.13 is responsible for any federal disallowances. The county or tribe may share this responsibility  
154.14 with its contracted vendors.

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

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

154.19 (2) programming the information systems.

154.20 (l) Payments to counties and tribal agencies for case management expenditures under  
154.21 this section shall only be made from federal earnings from services provided under this  
154.22 section. When this service is paid by the state without a federal share through fee-for-service,  
154.23 50 percent of the cost shall be provided by the state. Payments to county-contracted vendors  
154.24 shall include the federal earnings, the state share, and the county share.

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

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

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

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

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

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

155.7 **EFFECTIVE DATE.** This section is effective upon federal approval. The commissioner  
155.8 of human services shall notify the revisor of statutes when federal approval is obtained.

155.9 Sec. 36. **[256G.061] WITHDRAWAL MANAGEMENT SERVICES.**

155.10 The county of financial responsibility for withdrawal management services is defined  
155.11 in section 256G.02, subdivision 4.

155.12 Sec. 37. Minnesota Statutes 2024, section 256L.03, subdivision 5, is amended to read:

155.13 Subd. 5. **Cost-sharing.** (a) Co-payments, coinsurance, and deductibles do not apply to  
155.14 children under the age of 21 and to American Indians as defined in Code of Federal  
155.15 Regulations, title 42, section 600.5.

155.16 (b) The commissioner must adjust co-payments, coinsurance, and deductibles for covered  
155.17 services in a manner sufficient to maintain the actuarial value of the benefit to 94 percent.  
155.18 The cost-sharing changes described in this paragraph do not apply to eligible recipients or  
155.19 services exempt from cost-sharing under state law. The cost-sharing changes described in  
155.20 this paragraph shall not be implemented prior to January 1, 2016.

155.21 (c) The cost-sharing changes authorized under paragraph (b) must satisfy the requirements  
155.22 for cost-sharing under the Basic Health Program as set forth in Code of Federal Regulations,  
155.23 title 42, sections 600.510 and 600.520.

155.24 (d) Cost-sharing for prescription drugs and related medical supplies to treat chronic  
155.25 disease must comply with the requirements of section 62Q.481.

155.26 (e) Co-payments, coinsurance, and deductibles do not apply to additional diagnostic  
155.27 services or testing that a health care provider determines an enrollee requires after a  
155.28 mammogram, as specified under section 62A.30, subdivision 5.

155.29 (f) Cost-sharing must not apply to drugs used for tobacco and nicotine cessation or to  
155.30 tobacco and nicotine cessation services covered under section 256B.0625, subdivision 68.

156.1 (g) Co-payments, coinsurance, and deductibles do not apply to pre-exposure prophylaxis  
156.2 (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or  
156.3 treatment of the human immunodeficiency virus (HIV).

156.4 (h) Co-payments, coinsurance, and deductibles do not apply to mobile crisis intervention  
156.5 or crisis assessment as defined in section 256B.0624, subdivision 2.

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

156.9 Sec. 38. **REVISOR INSTRUCTION.**

156.10 The revisor of statutes shall substitute the term "substance use disorder assessment" or  
156.11 similar terms for "chemical dependency assessment" or similar terms, for "chemical use  
156.12 assessment" or similar terms, and for "comprehensive substance use disorder assessment"  
156.13 or similar terms wherever they appear in Minnesota Statutes, chapter 169A, and Minnesota  
156.14 Rules, chapter 7503, when referring to the assessments required under Minnesota Statutes,  
156.15 section 169A.70, or the charges or surcharges associated with such assessments.

## 156.16 **ARTICLE 5**

### 156.17 **DEPARTMENT OF HUMAN SERVICES OFFICE OF INSPECTOR GENERAL**

156.18 Section 1. Minnesota Statutes 2024, section 142E.51, subdivision 5, is amended to read:

156.19 Subd. 5. **Administrative disqualification of child care providers caring for children**  
156.20 **receiving child care assistance.** (a) The department shall pursue an administrative  
156.21 disqualification; if the child care provider is accused of committing an intentional program  
156.22 violation, ~~in lieu of a criminal action when it has not been pursued~~ the department refers  
156.23 the investigation to a law enforcement or prosecutorial agency for possible criminal  
156.24 prosecution, and the law enforcement or prosecutorial agency does not pursue a criminal  
156.25 action. Intentional program violations include intentionally making false or misleading  
156.26 statements; intentionally offering, providing, soliciting, or receiving illegal remuneration  
156.27 as described in subdivision 6a or in violation of section 609.542, subdivision 2; intentionally  
156.28 misrepresenting, concealing, or withholding facts; and repeatedly and intentionally violating  
156.29 program regulations under this chapter. No conviction is required before the department  
156.30 pursues an administrative disqualification. Intent may be proven by demonstrating a pattern  
156.31 of conduct that violates program rules under this chapter.

157.1 (b) To initiate an administrative disqualification, the commissioner must send written  
157.2 notice using a signature-verified confirmed delivery method to the provider against whom  
157.3 the action is being taken. Unless otherwise specified under this chapter or Minnesota Rules,  
157.4 chapter 3400, the commissioner must send the written notice at least 15 calendar days before  
157.5 the adverse action's effective date. The notice shall state (1) the factual basis for the agency's  
157.6 determination, (2) the action the agency intends to take, (3) the dollar amount of the monetary  
157.7 recovery or recoupment, if known, and (4) the provider's right to appeal the agency's proposed  
157.8 action.

157.9 (c) The provider may appeal an administrative disqualification by submitting a written  
157.10 request to the state agency. A provider's request must be received by the state agency no  
157.11 later than 30 days after the date the commissioner mails the notice.

157.12 (d) The provider's appeal request must contain the following:

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

157.15 (2) the computation the provider believes to be correct, if applicable;

157.16 (3) the statute or rule relied on for each disputed item; and

157.17 (4) the name, address, and telephone number of the person at the provider's place of  
157.18 business with whom contact may be made regarding the appeal.

157.19 (e) On appeal, the issuing agency bears the burden of proof to demonstrate by a  
157.20 preponderance of the evidence that the provider committed an intentional program violation.

157.21 (f) The hearing is subject to the requirements of section 142A.20. The human services  
157.22 judge may combine a fair hearing and administrative disqualification hearing into a single  
157.23 hearing if the factual issues arise out of the same or related circumstances and the provider  
157.24 receives prior notice that the hearings will be combined.

157.25 (g) A provider found to have committed an intentional program violation and is  
157.26 administratively disqualified must be disqualified, for a period of three years for the first  
157.27 offense and permanently for any subsequent offense, from receiving any payments from  
157.28 any child care program under this chapter.

157.29 (h) Unless a timely and proper appeal made under this section is received by the  
157.30 department, the administrative determination of the department is final and binding.

158.1 Sec. 2. Minnesota Statutes 2024, section 142E.51, subdivision 6, is amended to read:

158.2 Subd. 6. **Prohibited hiring practice practices.** ~~It is prohibited to~~ A person must not  
158.3 hire a child care center employee when, as a condition of employment, the employee is  
158.4 required to have one or more children who are eligible for or receive child care assistance,  
158.5 if:

158.6 (1) the individual hiring the employee is, or is acting at the direction of or in cooperation  
158.7 with, a child care center provider, center owner, director, manager, license holder, or other  
158.8 controlling individual; and

158.9 (2) the individual hiring the employee knows or has reason to know the purpose in hiring  
158.10 the employee is to obtain child care assistance program funds.

158.11 Sec. 3. Minnesota Statutes 2024, section 142E.51, is amended by adding a subdivision to  
158.12 read:

158.13 Subd. 6a. **Illegal remuneration.** (a) Except as provided in paragraph (b), program  
158.14 applicants, participants, and providers must not offer, provide, solicit, or receive money, a  
158.15 discount, a credit, a waiver, a rebate, a good, a service, employment, or anything else of  
158.16 value in exchange for:

158.17 (1) obtaining or attempting to obtain child care assistance program benefits; or

158.18 (2) directing a person's child care assistance program benefits to a particular provider.

158.19 (b) The prohibition in paragraph (a) does not apply to:

158.20 (1) marketing or promotional offerings that directly benefit an applicant or recipient's  
158.21 child or dependent for whom the child care provider is providing child care services; or

158.22 (2) child care provider discounts, scholarships, or other financial assistance allowed  
158.23 under section 142E.17, subdivision 7.

158.24 (c) An attempt to buy or sell access to a family's child care assistance program benefits  
158.25 to an unauthorized person by an applicant, a participant, or a provider is an intentional  
158.26 program violation under subdivision 5 and wrongfully obtaining assistance under section  
158.27 256.98.

158.28 Sec. 4. Minnesota Statutes 2024, section 144.651, subdivision 2, is amended to read:

158.29 Subd. 2. **Definitions.** For the purposes of this section, "patient" means a person who is  
158.30 admitted to an acute care inpatient facility for a continuous period longer than 24 hours, for  
158.31 the purpose of diagnosis or treatment bearing on the physical or mental health of that person.

159.1 For purposes of subdivisions 4 to 9, 12, 13, 15, 16, and 18 to 20, "patient" also means a  
159.2 person who receives health care services at an outpatient surgical center or at a birth center  
159.3 licensed under section 144.615. "Patient" also means a ~~minor~~ person who is admitted to a  
159.4 residential program as defined in section 253C.01. "Patient" also means a person who is  
159.5 admitted to a residential substance use disorder treatment program licensed according to  
159.6 Minnesota Rules, parts 2960.0430 to 2960.0490. For purposes of subdivisions 1, 3 to 16,  
159.7 18, 20 and 30, "patient" also means any person who is receiving mental health treatment or  
159.8 substance use disorder treatment on an outpatient basis or in a community support program  
159.9 or other community-based program. "Resident" means a person who is admitted to a nonacute  
159.10 care facility including extended care facilities, nursing homes, and boarding care homes for  
159.11 care required because of prolonged mental or physical illness or disability, recovery from  
159.12 injury or disease, or advancing age. For purposes of all subdivisions except subdivisions  
159.13 28 and 29, "resident" also means a person who is admitted to a facility licensed as a board  
159.14 and lodging facility under Minnesota Rules, parts 4625.0100 to 4625.2355, a boarding care  
159.15 home under sections 144.50 to 144.56, or a supervised living facility under Minnesota Rules,  
159.16 parts 4665.0100 to 4665.9900, and ~~which~~ that operates a ~~rehabilitation~~ withdrawal  
159.17 management program licensed under chapter 245F, a residential substance use disorder  
159.18 treatment program licensed under chapter 245G or, an intensive residential treatment services  
159.19 or residential crisis stabilization program licensed under chapter 245I, or a detoxification  
159.20 program licensed under Minnesota Rules, parts 9530.6510 to 9530.6590.

159.21 Sec. 5. Minnesota Statutes 2024, section 245A.04, subdivision 1, is amended to read:

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

159.32 The commissioner shall act on the application within 90 working days after a complete  
159.33 application and any required reports have been received from other state agencies or  
159.34 departments, counties, municipalities, or other political subdivisions. The commissioner

160.1 shall not consider an application to be complete until the commissioner receives all of the  
160.2 required information.

160.3 When the commissioner receives an application for initial licensure that is incomplete  
160.4 because the applicant failed to submit required documents or that is substantially deficient  
160.5 because the documents submitted do not meet licensing requirements, the commissioner  
160.6 shall provide the applicant written notice that the application is incomplete or substantially  
160.7 deficient. In the written notice to the applicant the commissioner shall identify documents  
160.8 that are missing or deficient and give the applicant 45 days to resubmit a second application  
160.9 that is substantially complete. An applicant's failure to submit a substantially complete  
160.10 application after receiving notice from the commissioner is a basis for license denial under  
160.11 section 245A.043.

160.12 (b) An application for licensure must identify all controlling individuals as defined in  
160.13 section 245A.02, subdivision 5a, and must designate one individual to be the authorized  
160.14 agent. The application must be signed by the authorized agent and must include the authorized  
160.15 agent's first, middle, and last name; mailing address; and email address. By submitting an  
160.16 application for licensure, the authorized agent consents to electronic communication with  
160.17 the commissioner throughout the application process. The authorized agent must be  
160.18 authorized to accept service on behalf of all of the controlling individuals. A government  
160.19 entity that holds multiple licenses under this chapter may designate one authorized agent  
160.20 for all licenses issued under this chapter or may designate a different authorized agent for  
160.21 each license. Service on the authorized agent is service on all of the controlling individuals.  
160.22 It is not a defense to any action arising under this chapter that service was not made on each  
160.23 controlling individual. The designation of a controlling individual as the authorized agent  
160.24 under this paragraph does not affect the legal responsibility of any other controlling individual  
160.25 under this chapter.

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

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

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

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

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

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

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

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

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

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

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

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

161.27 (3) the first, middle, and last name, and address for all individuals who will be controlling  
161.28 individuals, including all officers, owners, and managerial officials as defined in section  
161.29 245A.02, subdivision 5a, and the date that the background study was initiated by the applicant  
161.30 for each controlling individual;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

163.2 Sec. 6. Minnesota Statutes 2024, section 245A.04, subdivision 7, is amended to read:

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

163.7 (1) the name of the license holder;

163.8 (2) the address of the program;

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

163.10 (4) the type of license;

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

163.12 and

163.13 (6) any special conditions of licensure.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

164.23 (h) The commissioner shall not issue or reissue a license under this chapter if an individual  
164.24 living in the household where the services will be provided as specified under section  
164.25 245C.03, subdivision 1, has been disqualified and the disqualification has not been set aside  
164.26 and no variance has been granted.

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

164.33 (j) Notwithstanding paragraph (i), when a revocation is based on the disqualification of  
164.34 a controlling individual or license holder, and the controlling individual or license holder

165.1 is ordered under section 245C.17 to be immediately removed from direct contact with  
165.2 persons receiving services or is ordered to be under continuous, direct supervision when  
165.3 providing direct contact services, the program may continue to operate only if the program  
165.4 complies with the order and submits documentation demonstrating compliance with the  
165.5 order. If the disqualified individual fails to submit a timely request for reconsideration, or  
165.6 if the disqualification is not set aside and no variance is granted, the order to immediately  
165.7 remove the individual from direct contact or to be under continuous, direct supervision  
165.8 remains in effect pending the outcome of a hearing and final order from the commissioner.

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

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

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

165.23 Sec. 7. Minnesota Statutes 2024, section 245A.042, is amended by adding a subdivision  
165.24 to read:

165.25 Subd. 7. **Technical assistance and legal referrals required.** If requested by a license  
165.26 holder that is subject to an enforcement action under section 245A.06 or 245A.07 and  
165.27 operating a program licensed under this chapter and chapter 245D, the commissioner must  
165.28 provide the license holder with requested technical assistance or must comply with a request  
165.29 for a referral to legal assistance.

165.30 Sec. 8. Minnesota Statutes 2024, section 245A.16, subdivision 1, is amended to read:

165.31 Subdivision 1. **Delegation of authority to agencies.** (a) County agencies that have been  
165.32 designated by the commissioner to perform licensing functions and activities under section  
165.33 245A.04; to recommend denial of applicants under section 245A.05; to issue correction

166.1 orders, to issue variances, and recommend a conditional license under section 245A.06; or  
166.2 to recommend suspending or revoking a license or issuing a fine under section 245A.07,  
166.3 shall comply with rules and directives of the commissioner governing those functions and  
166.4 with this section. The following variances are excluded from the delegation of variance  
166.5 authority and may be issued only by the commissioner:

166.6 (1) dual licensure of child foster residence setting and community residential setting;

166.7 (2) until the responsibility for family child foster care transfers to the commissioner of  
166.8 children, youth, and families under Laws 2023, chapter 70, article 12, section 30, dual  
166.9 licensure of family child foster care and family adult foster care;

166.10 (3) until the responsibility for family child care transfers to the commissioner of children,  
166.11 youth, and families under Laws 2023, chapter 70, article 12, section 30, dual licensure of  
166.12 family adult foster care and family child care;

166.13 (4) adult foster care or community residential setting maximum capacity;

166.14 (5) adult foster care or community residential setting minimum age requirement;

166.15 (6) child foster care maximum age requirement;

166.16 (7) variances regarding disqualified individuals;

166.17 (8) the required presence of a caregiver in the adult foster care residence during normal  
166.18 sleeping hours;

166.19 (9) variances to requirements relating to chemical use problems of a license holder or a  
166.20 household member of a license holder; and

166.21 (10) variances to section 142B.46 for the use of a cradleboard for a cultural  
166.22 accommodation.

166.23 (b) Once the respective responsibilities transfer from the commissioner of human services  
166.24 to the commissioner of children, youth, and families, under Laws 2023, chapter 70, article  
166.25 12, section 30, the commissioners of human services and children, youth, and families must  
166.26 both approve a variance for dual licensure of family child foster care and family adult foster  
166.27 care or family adult foster care and family child care. Variances under this paragraph are  
166.28 excluded from the delegation of variance authority and may be issued only by both  
166.29 commissioners.

166.30 ~~(c) For family adult day services programs, the commissioner may authorize licensing~~  
166.31 ~~reviews every two years after a licensee has had at least one annual review.~~

167.1 ~~(d)~~ (c) An adult foster care, family adult day services, child foster residence setting,  
167.2 or community residential services license issued under this section may be issued for up to  
167.3 two years until implementation of the provider licensing and reporting hub. Upon  
167.4 implementation of the provider licensing and reporting hub, licenses may be issued each  
167.5 calendar year.

167.6 ~~(e)~~ (d) During implementation of chapter 245D, the commissioner shall consider:

167.7 (1) the role of counties in quality assurance;

167.8 (2) the duties of county licensing staff; and

167.9 (3) the possible use of joint powers agreements, according to section 471.59, with counties  
167.10 through which some licensing duties under chapter 245D may be delegated by the  
167.11 commissioner to the counties.

167.12 Any consideration related to this paragraph must meet all of the requirements of the corrective  
167.13 action plan ordered by the federal Centers for Medicare and Medicaid Services.

167.14 ~~(f)~~ (e) Licensing authority specific to section 245D.06, subdivisions 5, 6, 7, and 8, or  
167.15 successor provisions; and section 245D.061 or successor provisions, for family child foster  
167.16 care programs providing out-of-home respite, as identified in section 245D.03, subdivision  
167.17 1, paragraph (b), clause (1), is excluded from the delegation of authority to county agencies.

167.18 Sec. 9. Minnesota Statutes 2024, section 245A.242, subdivision 2, is amended to read:

167.19 **Subd. 2. Emergency overdose treatment.** (a) A license holder must maintain a supply  
167.20 of opiate antagonists as defined in section 604A.04, subdivision 1, available for emergency  
167.21 treatment of opioid overdose and must have a written standing order protocol by a physician  
167.22 who is licensed under chapter 147, advanced practice registered nurse who is licensed under  
167.23 chapter 148, or physician assistant who is licensed under chapter 147A, that permits the  
167.24 license holder to maintain a supply of opiate antagonists on site. A license holder must  
167.25 require staff to undergo training in the specific mode of administration used at the program,  
167.26 which may include intranasal administration, intramuscular injection, or both, before the  
167.27 staff has direct contact, as defined in section 245C.02, subdivision 11, with a person served  
167.28 by the program.

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

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

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

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

168.14 Sec. 10. Minnesota Statutes 2024, section 245C.05, is amended by adding a subdivision  
168.15 to read:

168.16 Subd. 9. **Electronic signature.** For documentation requiring a signature under this  
168.17 chapter, use of an electronic signature as defined under section 325L.02, paragraph (h), is  
168.18 allowed.

168.19 Sec. 11. Minnesota Statutes 2024, section 245C.08, subdivision 3, is amended to read:

168.20 Subd. 3. **Arrest and investigative information.** (a) For any background study completed  
168.21 under this section, if the commissioner has reasonable cause to believe the information is  
168.22 pertinent to the disqualification of an individual, the commissioner also may review arrest  
168.23 and investigative information from:

168.24 (1) the Bureau of Criminal Apprehension;

168.25 (2) the commissioners of children, youth, and families; health; and human services;

168.26 (3) a ~~county attorney~~ prosecutor;

168.27 ~~(4) a county sheriff~~;

168.28 ~~(5) (4)~~ (4) a county agency;

168.29 ~~(6) (5)~~ (5) a ~~local chief of police~~ law enforcement agency;

168.30 ~~(7) (6)~~ (6) other states;

169.1 ~~(8)~~ (7) the courts;  
169.2 ~~(9)~~ (8) the Federal Bureau of Investigation;  
169.3 ~~(10)~~ (9) the National Criminal Records Repository; and  
169.4 ~~(11)~~ (10) criminal records from other states.

169.5 (b) Except when specifically required by law, the commissioner is not required to conduct  
169.6 more than one review of a subject's records from the Federal Bureau of Investigation if a  
169.7 review of the subject's criminal history with the Federal Bureau of Investigation has already  
169.8 been completed by the commissioner and there has been no break in the subject's affiliation  
169.9 with the entity that initiated the background study.

169.10 (c) If the commissioner conducts a national criminal history record check when required  
169.11 by law and uses the information from the national criminal history record check to make a  
169.12 disqualification determination, the data obtained is private data and cannot be shared with  
169.13 private agencies or prospective employers of the background study subject.

169.14 (d) If the commissioner conducts a national criminal history record check when required  
169.15 by law and uses the information from the national criminal history record check to make a  
169.16 disqualification determination, the license holder or entity that submitted the study is not  
169.17 required to obtain a copy of the background study subject's disqualification letter under  
169.18 section 245C.17, subdivision 3.

169.19 Sec. 12. Minnesota Statutes 2024, section 245C.22, subdivision 5, is amended to read:

169.20 Subd. 5. **Scope of set-aside.** (a) If the commissioner sets aside a disqualification under  
169.21 this section, the disqualified individual remains disqualified, but may hold a license and  
169.22 have direct contact with or access to persons receiving services. Except as provided in  
169.23 paragraph (b), the commissioner's set-aside of a disqualification is limited solely to the  
169.24 licensed program, applicant, or agency specified in the set aside notice under section 245C.23.  
169.25 For personal care provider organizations, financial management services organizations,  
169.26 community first services and supports organizations, unlicensed home and community-based  
169.27 organizations, and consumer-directed community supports organizations, the commissioner's  
169.28 set-aside may further be limited to a specific individual who is receiving services. For new  
169.29 background studies required under section 245C.04, subdivision 1, paragraph (h), if an  
169.30 individual's disqualification was previously set aside for the license holder's program and  
169.31 the new background study results in no new information that indicates the individual may  
169.32 pose a risk of harm to persons receiving services from the license holder, the previous  
169.33 set-aside shall remain in effect.

170.1 (b) If the commissioner has previously set aside an individual's disqualification for one  
170.2 or more programs or agencies, and the individual is the subject of a subsequent background  
170.3 study for a different program or agency, the commissioner shall determine whether the  
170.4 disqualification is set aside for the program or agency that initiated the subsequent  
170.5 background study. A notice of a set-aside under paragraph (c) shall be issued within 15  
170.6 working days if all of the following criteria are met:

170.7 (1) the subsequent background study was initiated in connection with a program licensed  
170.8 or regulated under the same provisions of law and rule for at least one program for which  
170.9 the individual's disqualification was previously set aside by the commissioner;

170.10 (2) the individual is not disqualified for an offense specified in section 245C.15,  
170.11 subdivision 1 or 2;

170.12 (3) the commissioner has received no new information to indicate that the individual  
170.13 may pose a risk of harm to any person served by the program; and

170.14 (4) the previous set-aside was not limited to a specific person receiving services.

170.15 (c) Notwithstanding paragraph (b), clause (2), for an individual who is employed in the  
170.16 substance use disorder field, if the commissioner has previously set aside an individual's  
170.17 disqualification for one or more programs or agencies in the substance use disorder treatment  
170.18 field, and the individual is the subject of a subsequent background study for a different  
170.19 program or agency in the substance use disorder treatment field, the commissioner shall set  
170.20 aside the disqualification for the program or agency in the substance use disorder treatment  
170.21 field that initiated the subsequent background study when the criteria under paragraph (b),  
170.22 clauses (1), (3), and (4), are met and the individual is not disqualified for an offense specified  
170.23 in section 245C.15, subdivision 1. A notice of a set-aside under paragraph (d) shall be issued  
170.24 within 15 working days.

170.25 (d) When a disqualification is set aside under paragraph (b), the notice of background  
170.26 study results issued under section 245C.17, in addition to the requirements under section  
170.27 245C.17, shall state that the disqualification is set aside for the program or agency that  
170.28 initiated the subsequent background study. The notice must inform the individual that the  
170.29 individual may request reconsideration of the disqualification under section 245C.21 on the  
170.30 basis that the information used to disqualify the individual is incorrect.

170.31 Sec. 13. Minnesota Statutes 2024, section 245D.02, subdivision 4a, is amended to read:

170.32 Subd. 4a. **Community residential setting.** "Community residential setting" means a  
170.33 residential program as identified in section 245A.11, subdivision 8, where residential supports

171.1 and services identified in section 245D.03, subdivision 1, paragraph (c), clause (3), items  
171.2 (i) and (ii), are provided to adults, as defined in section 245A.02, subdivision 2, and the  
171.3 license holder is the owner, lessor, or tenant of the facility licensed according to this chapter,  
171.4 and the license holder does not reside in the facility.

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

171.6 Sec. 14. Minnesota Statutes 2024, section 245G.05, subdivision 1, is amended to read:

171.7 Subdivision 1. **Comprehensive assessment.** A comprehensive assessment of the client's  
171.8 substance use disorder must be administered face-to-face by an alcohol and drug counselor  
171.9 within five calendar days from the day of service initiation for a residential program or by  
171.10 the end of the fifth day on which a treatment service is provided in a nonresidential program.  
171.11 The number of days to complete the comprehensive assessment excludes the day of service  
171.12 initiation. If the comprehensive assessment is not completed within the required time frame,  
171.13 the person-centered reason for the delay and the planned completion date must be documented  
171.14 in the client's file. The comprehensive assessment is complete upon a qualified staff member's  
171.15 dated signature. If the client previously received a comprehensive assessment ~~that authorized~~  
171.16 ~~the treatment service~~, an alcohol and drug counselor may use the comprehensive assessment  
171.17 for requirements of this subdivision but must document a review of the comprehensive  
171.18 assessment and update the comprehensive assessment as clinically necessary to ensure  
171.19 compliance with this subdivision within applicable timelines. An alcohol and drug counselor  
171.20 must sign and date the comprehensive assessment review and update.

171.21 Sec. 15. Minnesota Statutes 2024, section 245G.06, subdivision 1, is amended to read:

171.22 Subdivision 1. **General.** Each client must have a person-centered individual treatment  
171.23 plan developed by an alcohol and drug counselor within ten days from the day of service  
171.24 initiation for a residential program, by the end of the tenth day on which a treatment session  
171.25 has been provided from the day of service initiation for a client in a nonresidential program,  
171.26 not to exceed 30 days. Opioid treatment programs must complete the individual treatment  
171.27 plan within ~~21~~ 14 days from the day of service initiation. The number of days to complete  
171.28 the individual treatment plan excludes the day of service initiation. The individual treatment  
171.29 plan must be signed by the client and the alcohol and drug counselor and document the  
171.30 client's involvement in the development of the plan. The individual treatment plan is  
171.31 developed upon the qualified staff member's dated signature. Treatment planning must  
171.32 include ongoing assessment of client needs. An individual treatment plan must be updated  
171.33 based on new information gathered about the client's condition, the client's level of

172.1 participation, and on whether methods identified have the intended effect. A change to the  
172.2 plan must be signed by the client and the alcohol and drug counselor. If the client chooses  
172.3 to have family or others involved in treatment services, the client's individual treatment plan  
172.4 must include how the family or others will be involved in the client's treatment. If a client  
172.5 is receiving treatment services or an assessment via telehealth and the alcohol and drug  
172.6 counselor documents the reason the client's signature cannot be obtained, the alcohol and  
172.7 drug counselor may document the client's verbal approval or electronic written approval of  
172.8 the treatment plan or change to the treatment plan in lieu of the client's signature.

172.9 Sec. 16. Minnesota Statutes 2024, section 245G.06, subdivision 2a, is amended to read:

172.10 Subd. 2a. **Documentation of treatment services.** The license holder must ensure that  
172.11 the staff member who provides the treatment service documents in the client record the  
172.12 date, type, and amount of each treatment service provided to a client and the client's response  
172.13 to each treatment service within seven days of providing the treatment service. In addition  
172.14 to the other requirements of this subdivision, if a guest speaker presents information during  
172.15 a treatment service, the alcohol and drug counselor who provided the service and is  
172.16 responsible for the information presented by the guest speaker must document the name of  
172.17 the guest speaker, date of service, time the presentation began, time the presentation ended,  
172.18 and a summary of the topic presentation.

172.19 Sec. 17. Minnesota Statutes 2024, section 245G.06, subdivision 3a, is amended to read:

172.20 Subd. 3a. **Frequency of treatment plan reviews.** (a) A license holder must ensure that  
172.21 the alcohol and drug counselor responsible for a client's treatment plan completes and  
172.22 documents a treatment plan review that meets the requirements of subdivision 3 in each  
172.23 client's file, according to the frequencies required in this subdivision. All ASAM levels  
172.24 referred to in this chapter are those described in section 254B.19, subdivision 1.

172.25 (b) For a client receiving residential ASAM level 3.3 or 3.5 high-intensity services or  
172.26 residential hospital-based services, a treatment plan review must be completed once every  
172.27 14 days.

172.28 (c) For a client receiving residential ASAM level 3.1 low-intensity services or any other  
172.29 residential level not listed in paragraph (b), a treatment plan review must be completed once  
172.30 every 30 days.

172.31 (d) For a client receiving nonresidential ASAM level 2.5 partial hospitalization services,  
172.32 a treatment plan review must be completed once every 14 days.

173.1 (e) For a client receiving nonresidential ASAM level 1.0 outpatient or 2.1 intensive  
173.2 outpatient services or any other nonresidential level not included in paragraph (d), a treatment  
173.3 plan review must be completed once every 30 days.

173.4 (f) For a client receiving nonresidential opioid treatment program services according to  
173.5 section 245G.22, a treatment plan review must be completed:

173.6 (1) weekly for the ten weeks following completion of the treatment plan; and

173.7 (2) monthly thereafter.

173.8 Treatment plan reviews must be completed more frequently when clinical needs warrant.

173.9 (g) The ten-week time frame in paragraph (f), clause (1), may include a client's previous  
173.10 time at another opioid treatment program licensed in Minnesota under section 245G.22 if:

173.11 (1) the client was enrolled in the other opioid treatment program immediately prior to  
173.12 admission to the license holder's program;

173.13 (2) the client did not miss taking a daily dose of medication to treat an opioid use disorder;  
173.14 and

173.15 (3) the license holder obtains from the previous opioid treatment program the client's  
173.16 number of days in comprehensive treatment, discharge summary, amount of daily milligram  
173.17 dose of medication for opioid use disorder, and previous three drug abuse test results.

173.18 ~~(g)~~ (h) Notwithstanding paragraphs (e) and (f), clause (2), for a client in a nonresidential  
173.19 program with a treatment plan that clearly indicates less than five hours of skilled treatment  
173.20 services will be provided to the client each month, a treatment plan review must be completed  
173.21 once every 90 days. Treatment plan reviews must be completed more frequently when  
173.22 clinical needs warrant.

173.23 Sec. 18. Minnesota Statutes 2024, section 245G.07, subdivision 2, is amended to read:

173.24 Subd. 2. **Additional treatment service.** A license holder may provide or arrange the  
173.25 following additional treatment service as a part of the client's individual treatment plan:

173.26 (1) relationship counseling provided by a qualified professional to help the client identify  
173.27 the impact of the client's substance use disorder on others and to help the client and persons  
173.28 in the client's support structure identify and change behaviors that contribute to the client's  
173.29 substance use disorder;

174.1 (2) therapeutic recreation to allow the client to participate in recreational activities  
174.2 without the use of mood-altering chemicals and to plan and select leisure activities that do  
174.3 not involve the inappropriate use of chemicals;

174.4 (3) stress management and physical well-being to help the client reach and maintain an  
174.5 appropriate level of health, physical fitness, and well-being;

174.6 (4) living skills development to help the client learn basic skills necessary for independent  
174.7 living;

174.8 (5) employment or educational services to help the client become financially independent;

174.9 (6) socialization skills development to help the client live and interact with others in a  
174.10 positive and productive manner;

174.11 (7) room, board, and supervision at the treatment site to provide the client with a safe  
174.12 and appropriate environment to gain and practice new skills; and

174.13 (8) peer recovery support services must be provided one-to-one and face-to-face, by a  
174.14 recovery peer ~~qualified~~ according to section 245I.04, subdivision 18. Peer recovery support  
174.15 services must be provided according to sections 254B.05, subdivision 5, and 254B.052, and  
174.16 may be provided through telehealth according to section 256B.0625, subdivision 3b.

174.17 Sec. 19. Minnesota Statutes 2024, section 245G.08, subdivision 6, is amended to read:

174.18 Subd. 6. **Control of drugs.** A license holder must have and implement written policies  
174.19 and procedures developed by a registered nurse that contain:

174.20 (1) a requirement that each drug must be stored in a locked compartment. A Schedule  
174.21 II drug, as defined by section 152.02, subdivision 3, must be stored in a separately locked  
174.22 compartment, permanently affixed to the physical plant or medication cart;

174.23 (2) a documentation system which that accounts for all ~~scheduled drugs each shift~~  
174.24 schedule II to V drugs listed in section 152.02, subdivisions 3 to 6;

174.25 (3) a procedure for recording the client's use of medication, including the signature of  
174.26 the staff member who completed the administration of the medication with the time and  
174.27 date;

174.28 (4) a procedure to destroy a discontinued, outdated, or deteriorated medication;

174.29 (5) a statement that only authorized personnel are permitted access to the keys to a locked  
174.30 compartment;

175.1 (6) a statement that no legend drug supply for one client shall be given to another client;  
175.2 and

175.3 (7) a procedure for monitoring the available supply of an opiate antagonist as defined  
175.4 in section 604A.04, subdivision 1, on site and replenishing the supply when needed.

175.5 Sec. 20. Minnesota Statutes 2024, section 245G.09, subdivision 3, is amended to read:

175.6 Subd. 3. **Contents.** (a) Client records must contain the following:

175.7 (1) documentation that the client was given:

175.8 (i) information on client rights and responsibilities; and grievance procedures, on the  
175.9 day of service initiation;

175.10 (ii) information on tuberculosis; and HIV; and that the client was provided within 72  
175.11 hours of service initiation;

175.12 (iii) an orientation to the program abuse prevention plan required under section 245A.65,  
175.13 subdivision 2, paragraph (a), clause (4). If the client has an opioid use disorder, the record  
175.14 must contain documentation that the client was provided within 24 hours of admission or,  
175.15 for clients who would benefit from a later orientation, 72 hours; and

175.16 (iv) opioid educational information material according to section 245G.04, subdivision  
175.17 3, on the day of service initiation;

175.18 (2) an initial services plan completed according to section 245G.04;

175.19 (3) a comprehensive assessment completed according to section 245G.05;

175.20 (4) an individual abuse prevention plan according to sections 245A.65, subdivision 2,  
175.21 and 626.557, subdivision 14, when applicable;

175.22 (5) an individual treatment plan according to section 245G.06, subdivisions 1 and 1a;

175.23 (6) documentation of treatment services, significant events, appointments, concerns, and  
175.24 treatment plan reviews according to section 245G.06, subdivisions 2a, 2b, 3, and 3a; and

175.25 (7) a summary at the time of service termination according to section 245G.06,  
175.26 subdivision 4.

175.27 (b) For a client that transfers to another of the license holder's licensed treatment locations,  
175.28 the license holder is not required to complete new documents or orientation for the client,  
175.29 except that the client must receive an orientation to the new location's grievance procedure,  
175.30 program abuse prevention plan, and maltreatment of minor and vulnerable adults reporting  
175.31 procedures.

176.1 Sec. 21. Minnesota Statutes 2024, section 245G.11, subdivision 11, is amended to read:

176.2 Subd. 11. **Individuals with temporary permit.** An individual with a temporary permit  
176.3 from the Board of Behavioral Health and Therapy may provide substance use disorder  
176.4 treatment ~~service~~ services and complete comprehensive assessments, individual treatment  
176.5 plans, treatment plan reviews, and service discharge summaries according to this subdivision  
176.6 if they meet the requirements of either paragraph (a) or (b).

176.7 (a) An individual with a temporary permit must be supervised by a licensed alcohol and  
176.8 drug counselor assigned by the license holder. The supervising licensed alcohol and drug  
176.9 counselor must document the amount and type of supervision provided at least on a weekly  
176.10 basis. The supervision must relate to the clinical practice.

176.11 (b) An individual with a temporary permit must be supervised by a clinical supervisor  
176.12 approved by the Board of Behavioral Health and Therapy. The supervision must be  
176.13 documented and meet the requirements of section 148F.04, subdivision 4.

176.14 Sec. 22. Minnesota Statutes 2024, section 245G.18, subdivision 2, is amended to read:

176.15 Subd. 2. **Alcohol and drug counselor qualifications.** In addition to the requirements  
176.16 specified in section 245G.11, subdivisions 1 and 5, an alcohol and drug counselor providing  
176.17 treatment service to an adolescent must have:

176.18 ~~(1)~~ an additional 30 hours of training or classroom instruction or one three-credit semester  
176.19 college course in adolescent development. ~~This~~ The training, classroom instruction, or  
176.20 college course must be completed no later than six months after the counselor first provides  
176.21 treatment services to adolescents and need only be completed one time; and. The training  
176.22 must be interactive and must not consist only of reading information. An alcohol and drug  
176.23 counselor who is also qualified as a mental health professional under section 245I.04,  
176.24 subdivision 2, is exempt from the requirement in this subdivision.

176.25 ~~(2) at least 150 hours of supervised experience as an adolescent counselor, either as a~~  
176.26 ~~student or as a staff member.~~

176.27 Sec. 23. Minnesota Statutes 2024, section 245G.19, subdivision 4, is amended to read:

176.28 Subd. 4. **Additional licensing requirements.** During the times the license holder is  
176.29 responsible for the supervision of a child, except for license holders described in subdivision  
176.30 5, the license holder must meet the following standards:

176.31 (1) child and adult ratios in Minnesota Rules, part 9502.0367;

- 177.1 (2) day care training in section 142B.70;
- 177.2 (3) behavior guidance in Minnesota Rules, part 9502.0395;
- 177.3 (4) activities and equipment in Minnesota Rules, part 9502.0415;
- 177.4 (5) physical environment in Minnesota Rules, part 9502.0425;
- 177.5 (6) physical space requirements in section 142B.72; and
- 177.6 (7) water, food, and nutrition in Minnesota Rules, part 9502.0445, unless the license
- 177.7 holder has a license from the Department of Health.

177.8 Sec. 24. Minnesota Statutes 2024, section 245G.19, is amended by adding a subdivision

177.9 to read:

177.10 Subd. 5. **Child care license exemption.** (a) License holders that only provide supervision

177.11 of children for less than three hours a day while the child's parent is in the same building

177.12 or contiguous building as allowed by the exclusion from licensure in section 245A.03,

177.13 subdivision 2, paragraph (a), clause (6), are exempt from the requirements of subdivision

177.14 4, if the requirements of this subdivision are met.

177.15 (b) During the times the license holder is responsible for the supervision of the child,

177.16 there must always be a staff member present that is responsible for supervising the child

177.17 who is trained in cardiopulmonary resuscitation (CPR) and first aid. This staff person must

177.18 be able to immediately contact the child's parent at all times.

177.19 Sec. 25. Minnesota Statutes 2024, section 245G.22, subdivision 1, is amended to read:

177.20 Subdivision 1. **Additional requirements.** (a) An opioid treatment program licensed

177.21 under this chapter must also: (1) comply with the requirements of this section and Code of

177.22 Federal Regulations, title 42, part 8; (2) be registered as a narcotic treatment program with

177.23 the Drug Enforcement Administration; (3) be accredited through an accreditation body

177.24 approved by the Division of Pharmacologic Therapy of the Center for Substance Abuse

177.25 Treatment; (4) be certified through the Division of Pharmacologic Therapy of the Center

177.26 for Substance Abuse Treatment; and (5) hold a license from the Minnesota Board of

177.27 Pharmacy or ~~equivalent agency~~ meet the requirements for dispensing by a practitioner in

177.28 section 151.37, subdivision 2, and Minnesota Rules, parts 6800.9950 to 6800.9954.

177.29 (b) A license holder operating under the dispensing by practitioner requirements in

177.30 section 151.37, subdivision 2, and Minnesota Rules, parts 6800.9950 to 6800.9954, must

177.31 maintain documentation that the practitioner responsible for complying with the above

178.1 statute and rules has signed a statement attesting that they are the practitioner responsible  
178.2 for complying with the applicable statutes and rules. If more than one person is responsible  
178.3 for compliance, all practitioners must sign a statement.

178.4 ~~(b)~~ (c) Where a standard in this section differs from a standard in an otherwise applicable  
178.5 administrative rule or statute, the standard of this section applies.

178.6 Sec. 26. Minnesota Statutes 2024, section 245G.22, subdivision 14, is amended to read:

178.7 Subd. 14. **Central registry.** ~~(a)~~ A license holder must comply with requirements to  
178.8 submit information and necessary consents to the state central registry for each client  
178.9 admitted, as specified by the commissioner. The license holder must submit data concerning  
178.10 medication used for the treatment of opioid use disorder. The data must be submitted in a  
178.11 method determined by the commissioner and the original information must be kept in the  
178.12 client's record. The information must be submitted for each client at admission and discharge.  
178.13 The program must document the date the information was submitted. The client's failure to  
178.14 provide the information shall prohibit participation in an opioid treatment program. The  
178.15 information submitted must include the client's:

178.16 (1) full name and all aliases;

178.17 (2) date of admission;

178.18 (3) date of birth;

178.19 (4) Social Security number or Alien Registration Number, if any; and

178.20 (5) current or previous enrollment status in another opioid treatment program;

178.21 ~~(6) government-issued photo identification card number; and~~

178.22 ~~(7) driver's license number, if any.~~

178.23 ~~(b) The requirements in paragraph (a) are effective upon the commissioner's~~  
178.24 ~~implementation of changes to the drug and alcohol abuse normative evaluation system or~~  
178.25 ~~development of an electronic system by which to submit the data.~~

178.26 Sec. 27. Minnesota Statutes 2024, section 245G.22, subdivision 15, is amended to read:

178.27 Subd. 15. **Nonmedication treatment services; documentation.** (a) The program must  
178.28 offer at least 50 consecutive minutes of individual or group therapy treatment services as  
178.29 defined in section 245G.07, subdivision 1, paragraph (a), clause (1), per week, for the first  
178.30 ten weeks following the day of service initiation, and at least 50 consecutive minutes per  
178.31 month thereafter. As clinically appropriate, the program may offer these services cumulatively

179.1 and not consecutively in increments of no less than 15 minutes over the required time period,  
179.2 and for a total of 60 minutes of treatment services over the time period, and must document  
179.3 the reason for providing services cumulatively in the client's record. The program may offer  
179.4 additional levels of service when deemed clinically necessary.

179.5 (b) The ten-week time frame may include a client's previous time at another opioid  
179.6 treatment program licensed in Minnesota under this section if:

179.7 (1) the client was enrolled in the other opioid treatment program immediately prior to  
179.8 admission to the license holder's program;

179.9 (2) the client did not miss taking a daily dose of medication to treat an opioid use disorder;  
179.10 and

179.11 (3) the license holder obtains from the previous opioid treatment program the client's  
179.12 number of days in comprehensive maintenance treatment, discharge summary, amount of  
179.13 daily milligram dose of medication for opioid use disorder, and previous three drug abuse  
179.14 test results.

179.15 ~~(b)~~ (c) Notwithstanding the requirements of comprehensive assessments in section  
179.16 245G.05, the assessment must be completed within 21 days from the day of service initiation.

179.17 Sec. 28. Minnesota Statutes 2024, section 256.98, subdivision 1, is amended to read:

179.18 Subdivision 1. **Wrongfully obtaining assistance.** (a) A person who commits any of the  
179.19 following acts or omissions with intent to defeat the purposes of sections 145.891 to 145.897,  
179.20 the MFIP program formerly codified in sections 256.031 to 256.0361, the AFDC program  
179.21 formerly codified in sections 256.72 to 256.871, chapter 142G, 256B, 256D, 256I, 256K,  
179.22 or 256L, child care assistance programs, and emergency assistance programs under section  
179.23 256D.06, is guilty of theft and shall be sentenced under section 609.52, subdivision 3, clauses  
179.24 (1) to (5):

179.25 (1) obtains or attempts to obtain, or aids or abets any person to obtain by means of a  
179.26 willfully false statement or representation, by intentional concealment of any material fact,  
179.27 or by impersonation or other fraudulent device, assistance or the continued receipt of  
179.28 assistance, to include child care assistance or food benefits produced according to sections  
179.29 145.891 to 145.897 and MinnesotaCare services according to sections 256.9365, 256.94,  
179.30 and 256L.01 to 256L.15, to which the person is not entitled or assistance greater than that  
179.31 to which the person is entitled;

179.32 (2) knowingly aids or abets in buying or in any way disposing of the property of a  
179.33 recipient or applicant of assistance without the consent of the county agency; or

180.1 (3) obtains or attempts to obtain, alone or in collusion with others, the receipt of payments  
180.2 to which the individual is not entitled as a provider of subsidized child care, ~~or~~<sub>2</sub> by ~~furnishing~~  
180.3 ~~or concurring in~~ offering, providing, soliciting, or receiving illegal remuneration as described  
180.4 in subdivision 6a or in violation of section 609.542, subdivision 2; or by submitting or aiding  
180.5 and abetting the submission of a willfully false claim for child care assistance.

180.6 (b) The continued receipt of assistance to which the person is not entitled or greater than  
180.7 that to which the person is entitled as a result of any of the acts, failure to act, or concealment  
180.8 described in this subdivision shall be deemed to be continuing offenses from the date that  
180.9 the first act or failure to act occurred.

180.10 Sec. 29. Minnesota Statutes 2024, section 256B.064, subdivision 1a, is amended to read:

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

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

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

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

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

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

180.24 (6) failure to repay an overpayment or a fine finally established under this section;

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

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

180.29 (b) For the purposes of this section, goods or services for which payment is made from  
180.30 medical assistance includes but is not limited to care and services identified in section  
180.31 256B.0625 or provided pursuant to any federally approved waiver.

181.1 (c) Regardless of the source of payment or other thing of value, the commissioner may  
181.2 impose sanctions against any individual or entity that solicits, receives, pays, or offers to  
181.3 pay any any illegal remuneration as described in section 256.98, subdivision 6a, in violation  
181.4 of section 609.542, subdivision 2, or in violation of United States Code, title 42, section  
181.5 1320a-7b(b)(1) or (2). No conviction is required before the commissioner can impose  
181.6 sanctions under this paragraph.

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

181.10 Sec. 30. Minnesota Statutes 2024, section 256I.04, subdivision 2c, is amended to read:

181.11 Subd. 2c. **Background study requirements.** ~~(a) Effective July 1, 2016,~~ A provider of  
181.12 housing support must initiate background studies in accordance with ~~chapter 245C of the~~  
181.13 ~~following individuals:~~ section 245C.03, subdivision 10.

181.14 ~~(1) controlling individuals as defined in section 245A.02;~~

181.15 ~~(2) managerial officials as defined in section 245A.02; and~~

181.16 ~~(3) all employees and volunteers of the establishment who have direct contact with~~  
181.17 ~~recipients, or who have unsupervised access to recipients, their personal property, or their~~  
181.18 ~~private data.~~

181.19 ~~(b) The provider of housing support must maintain compliance with all requirements~~  
181.20 ~~established for entities initiating background studies under chapter 245C~~ A provider initiating  
181.21 a background study pursuant to chapter 245C is not required to initiate a background study  
181.22 in accordance with sections 299C.66 to 299C.71 or chapter 364.

181.23 ~~(e) Effective July 1, 2017, a provider of housing support must demonstrate that all~~  
181.24 ~~individuals required to have a background study according to paragraph (a) have a notice~~  
181.25 ~~stating either that:~~

181.26 ~~(1) the individual is not disqualified under section 245C.14; or~~

181.27 ~~(2) the individual is disqualified, but the individual has been issued a set-aside of the~~  
181.28 ~~disqualification for that setting under section 245C.22.~~

181.29 Sec. 31. Minnesota Statutes 2024, section 480.40, subdivision 1, is amended to read:

181.30 Subdivision 1. **Definitions.** (a) For purposes of this section and section 480.45, the  
181.31 following terms have the meanings given.

182.1 (b) "Judicial official" means:

182.2 (1) every Minnesota district court judge, senior judge, retired judge, and every judge of  
182.3 the Minnesota Court of Appeals and every active, senior, recalled, or retired federal judge  
182.4 who resides in Minnesota;

182.5 (2) a justice of the Minnesota Supreme Court;

182.6 (3) employees of the Minnesota judicial branch;

182.7 (4) judicial referees and magistrate judges; and

182.8 (5) current and retired judges and current employees of the Office of Administrative  
182.9 Hearings, Department of Human Services Appeals Division, Workers' Compensation Court  
182.10 of Appeals, and Tax Court.

182.11 (c) "Personal information" does not include publicly available information. Personal  
182.12 information means:

182.13 (1) a residential address of a judicial official;

182.14 (2) a residential address of the spouse, domestic partner, or children of a judicial official;

182.15 (3) a nonjudicial branch issued telephone number or email address of a judicial official;

182.16 (4) the name of any child of a judicial official; and

182.17 (5) the name of any child care facility or school that is attended by a child of a judicial  
182.18 official if combined with an assertion that the named facility or school is attended by the  
182.19 child of a judicial official.

182.20 (d) "Publicly available information" means information that is lawfully made available  
182.21 through federal, state, or local government records or information that a business has a  
182.22 reasonable basis to believe is lawfully made available to the general public through widely  
182.23 distributed media, by a judicial official, or by a person to whom the judicial official has  
182.24 disclosed the information, unless the judicial official has restricted the information to a  
182.25 specific audience.

182.26 (e) "Law enforcement support organizations" do not include charitable organizations.

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

182.28 Sec. 32. **[609.542] ILLEGAL REMUNERATIONS.**

182.29 **Subdivision 1. Definition.** As used in this section, "federal health care program" has the  
182.30 meaning given in United States Code, title 42, section 1320a-7b(f).

183.1 Subd. 2. Human services program; unauthorized remuneration. (a) A person who  
183.2 intentionally solicits or receives money, a discount, a credit, a waiver, a rebate, a good, a  
183.3 service, employment, or anything else of value in return for doing any of the following is  
183.4 guilty of a crime and may be sentenced as provided in subdivision 4:

183.5 (1) referring an individual to a person for the furnishing or arranging for the furnishing  
183.6 of any item or service for which payment may be made in whole or in part under a federal  
183.7 health care program, behavioral health program under chapter 254B, or program under  
183.8 chapter 142E;

183.9 (2) purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing,  
183.10 or ordering any good, facility, service, or item for which payment may be made in whole  
183.11 or in part under a federal health care program, behavioral health program under chapter  
183.12 254B, or program under chapter 142E; or

183.13 (3) applying for or receiving any item or service for which payment may be made in  
183.14 whole or in part under a federal health care program, behavioral health program under  
183.15 chapter 254B, or program under chapter 142E.

183.16 (b) A person who intentionally offers or provides money, a discount, a credit, a waiver,  
183.17 a rebate, a good, a service, employment, or anything else of value to induce a person to do  
183.18 any of the following is guilty of a crime and may be sentenced as provided in subdivision  
183.19 4:

183.20 (1) refer an individual to a person for the furnishing or arranging for the furnishing of  
183.21 any item or service for which payment may be made in whole or in part under a federal  
183.22 health care program, behavioral health program under chapter 254B, or program under  
183.23 chapter 142E;

183.24 (2) purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering  
183.25 any good, facility, service, or item for which payment may be made in whole or in part  
183.26 under a federal health care program, behavioral health program under chapter 254B, or  
183.27 program under chapter 142E; or

183.28 (3) apply for or receive any item or service for which payment may be made in whole  
183.29 or in part under a federal health care program, behavioral health program under chapter  
183.30 254B, or program under chapter 142E.

183.31 Subd. 3. Exceptions. (a) Subdivision 2 does not apply to any payment, discount, waiver,  
183.32 or other remuneration exempted under United States Code, title 42, section 1320a-7b(b)(3),

184.1 or payment made under a federal health care program which is exempt from liability by  
184.2 United States Code, title 42, section 1001.952.

184.3 (b) For actions involving a program under chapter 142E, subdivision 2, does not apply  
184.4 to:

184.5 (1) any amount paid by an employer to a bona fide employee for providing covered  
184.6 items or services under chapter 142E while acting in the course and scope of employment;  
184.7 or

184.8 (2) child care provider discounts, scholarships, or other financial assistance to families  
184.9 allowed under section 142E.17, subdivision 7.

184.10 Subd. 4. **Penalties.** Whoever violates subdivision 2 may be sentenced as follows:

184.11 (1) to imprisonment of not more than 20 years or to payment of a fine of not more than  
184.12 \$100,000, or both, if the value of any money, discount, credit, waiver, rebate, good, service,  
184.13 employment, or other thing of value solicited, received, offered, or provided exceeds \$35,000;

184.14 (2) to imprisonment of not more than ten years or to payment of a fine of not more than  
184.15 \$20,000, or both, if the value of any money, discount, credit, waiver, rebate, good, service,  
184.16 employment, or other thing of value solicited, received, offered, or provided is more than  
184.17 \$5,000 but not more than \$35,000; or

184.18 (3) imprisonment for not more than five years or to payment of a fine of not more than  
184.19 \$10,000, or both, if the value of any money, discount, credit, waiver, rebate, good, service,  
184.20 employment, or other thing of value solicited, received, offered, or provided is not more  
184.21 than \$5,000.

184.22 Subd. 5. **Aggregation.** In a prosecution under this section, the value of any money,  
184.23 discount, credit, waiver, rebate, good, service, employment, or other thing of value solicited,  
184.24 received, offered, or provided within a six-month period may be aggregated and the defendant  
184.25 charged accordingly. When two or more offenses are committed by the same person in two  
184.26 or more counties, the accused may be prosecuted in any county in which one of the offenses  
184.27 was committed for all of the offenses aggregated under this subdivision.

184.28 Subd. 6. **False claims.** In addition to the penalties provided for in this section, a claim,  
184.29 as defined in section 15C.01, subdivision 2, that includes items or services resulting from  
184.30 a violation of this section constitutes a false or fraudulent claim for purposes of section  
184.31 15C.02.

184.32 **EFFECTIVE DATE.** This section is effective August 1, 2025, and applies to crimes  
184.33 committed on or after that date.

185.1 Sec. 33. Laws 2023, chapter 70, article 7, section 34, the effective date, is amended to  
185.2 read:

185.3 **EFFECTIVE DATE.** This section is effective ~~for background studies requested on or~~  
185.4 ~~after August 1, 2024~~ the day following final enactment.

185.5 Sec. 34. **MODIFICATION OF DEFINITIONS.**

185.6 (a) For the purposes of implementing the provider licensing and reporting hub, the  
185.7 commissioner of human services may modify definitions in Minnesota Statutes, chapters  
185.8 142B, 245A, 245D, 245F, 245G, and 245I, and Minnesota Rules, chapters 2960, 9502,  
185.9 9520, 9530, 9543, 9555, and 9570. Definitions changed pursuant to this section do not affect  
185.10 the rights, responsibilities, or duties of the commissioner; the Department of Human Services;  
185.11 programs administered, licensed, certified, or funded by the commissioner; or the programs'  
185.12 employees or clients.

185.13 (b) Notwithstanding Laws 1995, chapter 226, article 3, sections 50, 51, and 60, or any  
185.14 other law to the contrary, the joint rulemaking authority with the commissioner of corrections  
185.15 under Minnesota Rules, chapter 2960, does not apply to rule amendments applicable only  
185.16 to the Department of Human Services. A rule that is amending jointly administered rule  
185.17 parts must be related to requirements on the provider licensing and reporting hub.

185.18 (c) This section expires August 31, 2028.

185.19 Sec. 35. **REPEALER.**

185.20 (a) Minnesota Statutes 2024, section 245A.11, subdivision 8, is repealed.

185.21 (b) Minnesota Statutes 2024, section 245A.042, subdivisions 2, 3, and 4, are repealed.

185.22 **EFFECTIVE DATE.** Paragraph (a) is effective August 1, 2025.

## 185.23 **ARTICLE 6**

### 185.24 **ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL** 185.25 **TREATMENT SERVICES RECODIFICATION**

185.26 Section 1. Minnesota Statutes 2024, section 256B.0622, subdivision 1, is amended to read:

185.27 Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically  
185.28 necessary, assertive community treatment when the services are provided by an entity  
185.29 certified under and meeting the standards in this section.

186.1 ~~(b) Subject to federal approval, medical assistance covers medically necessary, intensive~~  
 186.2 ~~residential treatment services when the services are provided by an entity licensed under~~  
 186.3 ~~and meeting the standards in section 245I.23.~~

186.4 ~~(e)~~ (b) The provider entity must make reasonable and good faith efforts to report  
 186.5 individual client outcomes to the commissioner, using instruments and protocols approved  
 186.6 by the commissioner.

186.7 Sec. 2. Minnesota Statutes 2024, section 256B.0622, subdivision 8, is amended to read:

186.8 Subd. 8. **Medical assistance payment for assertive community treatment and**  
 186.9 **intensive residential treatment services.** (a) Payment for ~~intensive residential treatment~~  
 186.10 ~~services and~~ assertive community treatment in this section shall be based on one daily rate  
 186.11 per provider inclusive of the following services received by an eligible client in a given  
 186.12 calendar day: all rehabilitative services under this section, staff travel time to provide  
 186.13 rehabilitative services under this section, and nonresidential crisis stabilization services  
 186.14 under section 256B.0624.

186.15 (b) Except as indicated in paragraph ~~(d)~~ (c), payment will not be made to more than one  
 186.16 entity for each client for services provided under this section on a given day. If services  
 186.17 under this section are provided by a team that includes staff from more than one entity, the  
 186.18 team must determine how to distribute the payment among the members.

186.19 ~~(e) Payment must not be made based solely on a court order to participate in intensive~~  
 186.20 ~~residential treatment services. If a client has a court order to participate in the program or~~  
 186.21 ~~to obtain assessment for treatment and follow treatment recommendations, payment under~~  
 186.22 ~~this section must only be provided if the client is eligible for the service and the service is~~  
 186.23 ~~determined to be medically necessary.~~

186.24 ~~(d)~~ (c) The commissioner shall determine ~~one rate for each provider that will bill medical~~  
 186.25 ~~assistance for residential services under this section and one rate for each assertive community~~  
 186.26 ~~treatment provider under this section.~~ If a single entity provides both ~~services~~ intensive  
 186.27 residential treatment services under section 256B.0632 and assertive community treatment  
 186.28 under this section, one rate is established for the entity's intensive residential treatment  
 186.29 services under section 256B.0632 and another rate for the entity's ~~nonresidential~~ assertive  
 186.30 community treatment services under this section. A provider is not eligible for payment  
 186.31 under this section without authorization from the commissioner. The commissioner shall  
 186.32 develop rates using the following criteria:

187.1 (1) the provider's cost for services shall include direct services costs, other program  
187.2 costs, and other costs determined as follows:

187.3 (i) the direct services costs must be determined using actual costs of salaries, benefits,  
187.4 payroll taxes, and training of direct service staff and service-related transportation;

187.5 (ii) other program costs not included in item (i) must be determined as a specified  
187.6 percentage of the direct services costs as determined by item (i). The percentage used shall  
187.7 be determined by the commissioner based upon the average of percentages that represent  
187.8 the relationship of other program costs to direct services costs among the entities that provide  
187.9 similar services;

187.10 (iii) physical plant costs calculated based on the percentage of space within the program  
187.11 that is entirely devoted to treatment and programming. This does not include administrative  
187.12 or residential space;

187.13 (iv) assertive community treatment physical plant costs must be reimbursed as part of  
187.14 the costs described in item (ii); and

187.15 (v) subject to federal approval, up to an additional five percent of the total rate may be  
187.16 added to the program rate as a quality incentive based upon the entity meeting performance  
187.17 criteria specified by the commissioner;

187.18 (2) ~~actual cost~~ is costs are defined as costs which are allowable, allocable, and reasonable,  
187.19 and consistent with federal reimbursement requirements under Code of Federal Regulations,  
187.20 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and  
187.21 Budget Circular Number A-122, relating to nonprofit entities;

187.22 (3) the number of service units;

187.23 (4) the degree to which clients will receive services other than services under this section  
187.24 or section 256B.0632; and

187.25 (5) the costs of other services that will be separately reimbursed.

187.26 ~~(e)~~ (d) The rate for ~~intensive residential treatment services~~ and assertive community  
187.27 treatment must exclude the medical assistance room and board rate, as defined in section  
187.28 256B.056, subdivision 5d, and services not covered under this section, such as partial  
187.29 hospitalization, home care, and inpatient services.

187.30 ~~(f) Physician services that are not separately billed may be included in the rate to the~~  
187.31 ~~extent that a psychiatrist, or other health care professional providing physician services~~  
187.32 ~~within their scope of practice, is a member of the intensive residential treatment services~~

188.1 ~~treatment team. Physician services, whether billed separately or included in the rate, may~~  
188.2 ~~be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning~~  
188.3 ~~given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth~~  
188.4 ~~is used to provide intensive residential treatment services.~~

188.5 ~~(g)~~ (e) When services under this section are provided by an assertive community treatment  
188.6 provider, case management functions must be an integral part of the team.

188.7 ~~(h)~~ (f) The rate for a provider must not exceed the rate charged by that provider for the  
188.8 same service to other payors.

188.9 ~~(i)~~ (g) The rates for existing programs must be established prospectively based upon the  
188.10 expenditures and utilization over a prior 12-month period using the criteria established in  
188.11 paragraph ~~(d)~~ (c). The rates for new programs must be established based upon estimated  
188.12 expenditures and estimated utilization using the criteria established in paragraph ~~(d)~~ (c).

188.13 ~~(j)~~ (h) Effective for the rate years beginning on and after January 1, 2024, rates for  
188.14 assertive community treatment, adult residential crisis stabilization services, and intensive  
188.15 residential treatment services must be annually adjusted for inflation using the Centers for  
188.16 Medicare and Medicaid Services Medicare Economic Index, as forecasted in the third quarter  
188.17 of the calendar year before the rate year. The inflation adjustment must be based on the  
188.18 12-month period from the midpoint of the previous rate year to the midpoint of the rate year  
188.19 for which the rate is being determined. This paragraph expires upon federal approval.

188.20 (i) Effective upon the expiration of paragraph (h), and effective for the rate years  
188.21 beginning on and after January 1, 2024, rates for assertive community treatment services  
188.22 must be annually adjusted for inflation using the Centers for Medicare and Medicaid Services  
188.23 Medicare Economic Index, as forecasted in the third quarter of the calendar year before the  
188.24 rate year. The inflation adjustment must be based on the 12-month period from the midpoint  
188.25 of the previous rate year to the midpoint of the rate year for which the rate is being  
188.26 determined.

188.27 ~~(k)~~ (j) Entities who discontinue providing services must be subject to a settle-up process  
188.28 whereby actual costs and reimbursement for the previous 12 months are compared. In the  
188.29 event that the entity was paid more than the entity's actual costs plus any applicable  
188.30 performance-related funding due the provider, the excess payment must be reimbursed to  
188.31 the department. If a provider's revenue is less than actual allowed costs due to lower  
188.32 utilization than projected, the commissioner may reimburse the provider to recover its actual  
188.33 allowable costs. The resulting adjustments by the commissioner must be proportional to the

189.1 percent of total units of service reimbursed by the commissioner and must reflect a difference  
189.2 of greater than five percent.

189.3 ~~(j)~~ (k) A provider may request of the commissioner a review of any rate-setting decision  
189.4 made under this subdivision.

189.5 Sec. 3. Minnesota Statutes 2024, section 256B.0622, subdivision 11, is amended to read:

189.6 Subd. 11. **Sustainability grants.** The commissioner may disburse grant funds directly  
189.7 to ~~intensive residential treatment services providers and~~ assertive community treatment  
189.8 providers to maintain access to these services.

189.9 Sec. 4. Minnesota Statutes 2024, section 256B.0622, subdivision 12, is amended to read:

189.10 Subd. 12. **Start-up grants.** The commissioner may, within available appropriations,  
189.11 disburse grant funding to counties, Indian tribes, or mental health service providers to  
189.12 establish additional assertive community treatment teams, ~~intensive residential treatment~~  
189.13 ~~services, or crisis residential services.~~

189.14 Sec. 5. **[256B.0632] INTENSIVE RESIDENTIAL TREATMENT SERVICES.**

189.15 Subdivision 1. **Scope.** (a) Subject to federal approval, medical assistance covers medically  
189.16 necessary, intensive residential treatment services when the services are provided by an  
189.17 entity licensed under and meeting the standards in section 245I.23.

189.18 (b) The provider entity must make reasonable and good faith efforts to report individual  
189.19 client outcomes to the commissioner, using instruments and protocols approved by the  
189.20 commissioner.

189.21 Subd. 2. **Provider entity licensure and contract requirements for intensive residential**  
189.22 **treatment services.** (a) The commissioner shall develop procedures for counties and  
189.23 providers to submit other documentation as needed to allow the commissioner to determine  
189.24 whether the standards in this section are met.

189.25 (b) A provider entity must specify in the provider entity's application what geographic  
189.26 area and populations will be served by the proposed program. A provider entity must  
189.27 document that the capacity or program specialties of existing programs are not sufficient  
189.28 to meet the service needs of the target population. A provider entity must submit evidence  
189.29 of ongoing relationships with other providers and levels of care to facilitate referrals to and  
189.30 from the proposed program.

190.1 (c) A provider entity must submit documentation that the provider entity requested a  
190.2 statement of need from each county board and Tribal authority that serves as a local mental  
190.3 health authority in the proposed service area. The statement of need must specify if the local  
190.4 mental health authority supports or does not support the need for the proposed program and  
190.5 the basis for this determination. If a local mental health authority does not respond within  
190.6 60 days of the receipt of the request, the commissioner shall determine the need for the  
190.7 program based on the documentation submitted by the provider entity.

190.8 Subd. 3. **Medical assistance payment for intensive residential treatment services.** (a)  
190.9 Payment for intensive residential treatment services in this section shall be based on one  
190.10 daily rate per provider inclusive of the following services received by an eligible client in  
190.11 a given calendar day: all rehabilitative services under this section, staff travel time to provide  
190.12 rehabilitative services under this section, and nonresidential crisis stabilization services  
190.13 under section 256B.0624.

190.14 (b) Except as indicated in paragraph (d), payment will not be made to more than one  
190.15 entity for each client for services provided under this section on a given day. If services  
190.16 under this section are provided by a team that includes staff from more than one entity, the  
190.17 team must determine how to distribute the payment among the members.

190.18 (c) Payment must not be made based solely on a court order to participate in intensive  
190.19 residential treatment services. If a client has a court order to participate in the program or  
190.20 to obtain assessment for treatment and follow treatment recommendations, payment under  
190.21 this section must only be provided if the client is eligible for the service and the service is  
190.22 determined to be medically necessary.

190.23 (d) The commissioner shall determine one rate for each provider that will bill medical  
190.24 assistance for intensive residential treatment services under this section. If a single entity  
190.25 provides both intensive residential treatment services under this section and assertive  
190.26 community treatment under section 256B.0622, one rate is established for the entity's  
190.27 intensive residential treatment services under this section and another rate for the entity's  
190.28 assertive community treatment services under section 256B.0622. A provider is not eligible  
190.29 for payment under this section without authorization from the commissioner. The  
190.30 commissioner shall develop rates using the following criteria:

190.31 (1) the provider's cost for services shall include direct services costs, other program  
190.32 costs, and other costs determined as follows:

190.33 (i) the direct services costs must be determined using actual costs of salaries, benefits,  
190.34 payroll taxes, and training of direct service staff and service-related transportation;

191.1 (ii) other program costs not included in item (i) must be determined as a specified  
191.2 percentage of the direct services costs as determined by item (i). The percentage used shall  
191.3 be determined by the commissioner based upon the average of percentages that represent  
191.4 the relationship of other program costs to direct services costs among the entities that provide  
191.5 similar services;

191.6 (iii) physical plant costs calculated based on the percentage of space within the program  
191.7 that is entirely devoted to treatment and programming. This does not include administrative  
191.8 or residential space; and

191.9 (iv) subject to federal approval, up to an additional five percent of the total rate may be  
191.10 added to the program rate as a quality incentive based upon the entity meeting performance  
191.11 criteria specified by the commissioner;

191.12 (2) actual costs are defined as costs which are allowable, allocable, and reasonable, and  
191.13 consistent with federal reimbursement requirements under Code of Federal Regulations,  
191.14 title 48, chapter 1, part 31, relating to for-profit entities, and Office of Management and  
191.15 Budget Circular Number A-122, relating to nonprofit entities;

191.16 (3) the number of services units;

191.17 (4) the degree to which clients will receive services other than services under this section  
191.18 or section 256B.0622; and

191.19 (5) the costs of other services that will be separately reimbursed.

191.20 (e) The rate for intensive residential treatment services must exclude the medical  
191.21 assistance room and board rate, as defined in section 256B.056, subdivision 5d, and services  
191.22 not covered under this section, such as partial hospitalization, home care, and inpatient  
191.23 services.

191.24 (f) Physician services that are not separately billed may be included in the rate to the  
191.25 extent that a psychiatrist, or other health care professional providing physician services  
191.26 within their scope of practice, is a member of the intensive residential treatment services  
191.27 treatment team. Physician services, whether billed separately or included in the rate, may  
191.28 be delivered by telehealth. For purposes of this paragraph, "telehealth" has the meaning  
191.29 given to "mental health telehealth" in section 256B.0625, subdivision 46, when telehealth  
191.30 is used to provide intensive residential treatment services.

191.31 (g) The rate for a provider must not exceed the rate charged by that provider for the  
191.32 same service to other payors.

192.1 (h) The rates for existing programs must be established prospectively based upon the  
192.2 expenditures and utilization over a prior 12-month period using the criteria established in  
192.3 paragraph (d). The rates for new programs must be established based upon estimated  
192.4 expenditures and estimated utilization using the criteria established in paragraph (d).

192.5 (i) Effective upon the expiration of section 256B.0622, subdivision 8, paragraph (h),  
192.6 and effective for rate years beginning on and after January 1, 2024, rates for intensive  
192.7 residential treatment services and adult residential crisis stabilization services must be  
192.8 annually adjusted for inflation using the Centers for Medicare and Medicaid Services  
192.9 Medicare Economic Index, as forecasted in the third quarter of the calendar year before the  
192.10 rate year. The inflation adjustment must be based on the 12-month period from the midpoint  
192.11 of the previous rate year to the midpoint of the rate year for which the rate is being  
192.12 determined.

192.13 (j) Entities who discontinue providing services must be subject to a settle-up process  
192.14 whereby actual costs and reimbursement for the previous 12 months are compared. In the  
192.15 event that the entity was paid more than the entity's actual costs plus any applicable  
192.16 performance-related funding due the provider, the excess payment must be reimbursed to  
192.17 the department. If a provider's revenue is less than actual allowed costs due to lower  
192.18 utilization than projected, the commissioner may reimburse the provider to recover its actual  
192.19 allowable costs. The resulting adjustments by the commissioner must be proportional to the  
192.20 percent of total units of service reimbursed by the commissioner and must reflect a difference  
192.21 of greater than five percent.

192.22 (k) A provider may request of the commissioner a review of any rate-setting decision  
192.23 made under this subdivision.

192.24 **Subd. 4. Provider enrollment; rate setting for county-operated entities.** Counties  
192.25 that employ their own staff to provide services under this section shall apply directly to the  
192.26 commissioner for enrollment and rate setting. In this case, a county contract is not required.

192.27 **Subd. 5. Provider enrollment; rate setting for specialized program.** A county contract  
192.28 is not required for a provider proposing to serve a subpopulation of eligible clients under  
192.29 the following circumstances:

192.30 (1) the provider demonstrates that the subpopulation to be served requires a specialized  
192.31 program which is not available from county-approved entities; and

192.32 (2) the subpopulation to be served is of such a low incidence that it is not feasible to  
192.33 develop a program serving a single county or regional group of counties.

193.1 Subd. 6. **Sustainability grants.** The commissioner may disburse grant funds directly to  
 193.2 intensive residential treatment services providers to maintain access to these services.

193.3 Subd. 7. **Start-up grants.** The commissioner may, within available appropriations,  
 193.4 disburse grant funding to counties, Indian Tribes, or mental health service providers to  
 193.5 establish additional intensive residential treatment services and residential crisis services.

193.6 **Sec. 6. REPEALER.**

193.7 Minnesota Statutes 2024, section 256B.0622, subdivision 4, is repealed.

193.8 **ARTICLE 7**

193.9 **ASSERTIVE COMMUNITY TREATMENT AND INTENSIVE RESIDENTIAL**  
 193.10 **TREATMENT SERVICES RECODIFICATION CONFORMING CHANGES**

193.11 Section 1. Minnesota Statutes 2024, section 148F.11, subdivision 1, is amended to read:

193.12 Subdivision 1. **Other professionals.** (a) Nothing in this chapter prevents members of  
 193.13 other professions or occupations from performing functions for which they are qualified or  
 193.14 licensed. This exception includes, but is not limited to: licensed physicians; registered nurses;  
 193.15 licensed practical nurses; licensed psychologists and licensed psychological practitioners;  
 193.16 members of the clergy provided such services are provided within the scope of regular  
 193.17 ministries; American Indian medicine men and women; licensed attorneys; probation officers;  
 193.18 licensed marriage and family therapists; licensed social workers; social workers employed  
 193.19 by city, county, or state agencies; licensed professional counselors; licensed professional  
 193.20 clinical counselors; licensed school counselors; registered occupational therapists or  
 193.21 occupational therapy assistants; Upper Midwest Indian Council on Addictive Disorders  
 193.22 (UMICAD) certified counselors when providing services to Native American people; city,  
 193.23 county, or state employees when providing assessments or case management under Minnesota  
 193.24 Rules, chapter 9530; and staff persons providing co-occurring substance use disorder  
 193.25 treatment in adult mental health rehabilitative programs certified or licensed by the  
 193.26 Department of Human Services under section 245I.23, 256B.0622, ~~or 256B.0623,~~ or  
 193.27 256B.0632.

193.28 (b) Nothing in this chapter prohibits technicians and resident managers in programs  
 193.29 licensed by the Department of Human Services from discharging their duties as provided  
 193.30 in Minnesota Rules, chapter 9530.

193.31 (c) Any person who is exempt from licensure under this section must not use a title  
 193.32 incorporating the words "alcohol and drug counselor" or "licensed alcohol and drug  
 193.33 counselor" or otherwise hold himself or herself out to the public by any title or description

194.1 stating or implying that he or she is engaged in the practice of alcohol and drug counseling,  
194.2 or that he or she is licensed to engage in the practice of alcohol and drug counseling, unless  
194.3 that person is also licensed as an alcohol and drug counselor. Persons engaged in the practice  
194.4 of alcohol and drug counseling are not exempt from the board's jurisdiction solely by the  
194.5 use of one of the titles in paragraph (a).

194.6 Sec. 2. Minnesota Statutes 2024, section 245.4662, subdivision 1, is amended to read:

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

194.9 (b) "Community partnership" means a project involving the collaboration of two or more  
194.10 eligible applicants.

194.11 (c) "Eligible applicant" means an eligible county, Indian tribe, mental health service  
194.12 provider, hospital, or community partnership. Eligible applicant does not include a  
194.13 state-operated direct care and treatment facility or program under chapters 246 and 246C.

194.14 (d) "Intensive residential treatment services" has the meaning given in section ~~256B.0622~~  
194.15 256B.0632.

194.16 (e) "Metropolitan area" means the seven-county metropolitan area, as defined in section  
194.17 473.121, subdivision 2.

194.18 Sec. 3. Minnesota Statutes 2024, section 245.4906, subdivision 2, is amended to read:

194.19 Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider that  
194.20 employs a mental health certified peer specialist qualified under section 245I.04, subdivision  
194.21 10, and that provides services to individuals receiving assertive community treatment ~~or~~  
194.22 ~~intensive residential treatment services~~ under section 256B.0622, intensive residential  
194.23 treatment services under section 256B.0632, adult rehabilitative mental health services  
194.24 under section 256B.0623, or crisis response services under section 256B.0624.

194.25 Sec. 4. Minnesota Statutes 2024, section 254B.04, subdivision 1a, is amended to read:

194.26 Subd. 1a. **Client eligibility.** (a) Persons eligible for benefits under Code of Federal  
194.27 Regulations, title 25, part 20, who meet the income standards of section 256B.056,  
194.28 subdivision 4, and are not enrolled in medical assistance, are entitled to behavioral health  
194.29 fund services. State money appropriated for this paragraph must be placed in a separate  
194.30 account established for this purpose.

195.1 (b) Persons with dependent children who are determined to be in need of substance use  
195.2 disorder treatment pursuant to an assessment under section 260E.20, subdivision 1, or in  
195.3 need of chemical dependency treatment pursuant to a case plan under section 260C.201,  
195.4 subdivision 6, or 260C.212, shall be assisted by the local agency to access needed treatment  
195.5 services. Treatment services must be appropriate for the individual or family, which may  
195.6 include long-term care treatment or treatment in a facility that allows the dependent children  
195.7 to stay in the treatment facility. The county shall pay for out-of-home placement costs, if  
195.8 applicable.

195.9 (c) Notwithstanding paragraph (a), any person enrolled in medical assistance or  
195.10 MinnesotaCare is eligible for room and board services under section 254B.05, subdivision  
195.11 5, paragraph (b), clause (9).

195.12 (d) A client is eligible to have substance use disorder treatment paid for with funds from  
195.13 the behavioral health fund when the client:

195.14 (1) is eligible for MFIP as determined under chapter 142G;

195.15 (2) is eligible for medical assistance as determined under Minnesota Rules, parts  
195.16 9505.0010 to 9505.0150;

195.17 (3) is eligible for general assistance, general assistance medical care, or work readiness  
195.18 as determined under Minnesota Rules, parts 9500.1200 to 9500.1318; or

195.19 (4) has income that is within current household size and income guidelines for entitled  
195.20 persons, as defined in this subdivision and subdivision 7.

195.21 (e) Clients who meet the financial eligibility requirement in paragraph (a) and who have  
195.22 a third-party payment source are eligible for the behavioral health fund if the third-party  
195.23 payment source pays less than 100 percent of the cost of treatment services for eligible  
195.24 clients.

195.25 (f) A client is ineligible to have substance use disorder treatment services paid for with  
195.26 behavioral health fund money if the client:

195.27 (1) has an income that exceeds current household size and income guidelines for entitled  
195.28 persons as defined in this subdivision and subdivision 7; or

195.29 (2) has an available third-party payment source that will pay the total cost of the client's  
195.30 treatment.

195.31 (g) A client who is disenrolled from a state prepaid health plan during a treatment episode  
195.32 is eligible for continued treatment service that is paid for by the behavioral health fund until

196.1 the treatment episode is completed or the client is re-enrolled in a state prepaid health plan  
196.2 if the client:

196.3 (1) continues to be enrolled in MinnesotaCare, medical assistance, or general assistance  
196.4 medical care; or

196.5 (2) is eligible according to paragraphs (a) and (b) and is determined eligible by a local  
196.6 agency under section 254B.04.

196.7 (h) When a county commits a client under chapter 253B to a regional treatment center  
196.8 for substance use disorder services and the client is ineligible for the behavioral health fund,  
196.9 the county is responsible for the payment to the regional treatment center according to  
196.10 section 254B.05, subdivision 4.

196.11 (i) Persons enrolled in MinnesotaCare are eligible for room and board services when  
196.12 provided through intensive residential treatment services and residential crisis services under  
196.13 section ~~256B.0622~~ 256B.0632.

196.14 Sec. 5. Minnesota Statutes 2024, section 254B.05, subdivision 1a, is amended to read:

196.15 Subd. 1a. **Room and board provider requirements.** (a) Vendors of room and board  
196.16 are eligible for behavioral health fund payment if the vendor:

196.17 (1) has rules prohibiting residents bringing chemicals into the facility or using chemicals  
196.18 while residing in the facility and provide consequences for infractions of those rules;

196.19 (2) is determined to meet applicable health and safety requirements;

196.20 (3) is not a jail or prison;

196.21 (4) is not concurrently receiving funds under chapter 256I for the recipient;

196.22 (5) admits individuals who are 18 years of age or older;

196.23 (6) is registered as a board and lodging or lodging establishment according to section  
196.24 157.17;

196.25 (7) has awake staff on site whenever a client is present;

196.26 (8) has staff who are at least 18 years of age and meet the requirements of section  
196.27 245G.11, subdivision 1, paragraph (b);

196.28 (9) has emergency behavioral procedures that meet the requirements of section 245G.16;

196.29 (10) meets the requirements of section 245G.08, subdivision 5, if administering  
196.30 medications to clients;

197.1 (11) meets the abuse prevention requirements of section 245A.65, including a policy on  
197.2 fraternization and the mandatory reporting requirements of section 626.557;

197.3 (12) documents coordination with the treatment provider to ensure compliance with  
197.4 section 254B.03, subdivision 2;

197.5 (13) protects client funds and ensures freedom from exploitation by meeting the  
197.6 provisions of section 245A.04, subdivision 13;

197.7 (14) has a grievance procedure that meets the requirements of section 245G.15,  
197.8 subdivision 2; and

197.9 (15) has sleeping and bathroom facilities for men and women separated by a door that  
197.10 is locked, has an alarm, or is supervised by awake staff.

197.11 (b) Programs licensed according to Minnesota Rules, chapter 2960, are exempt from  
197.12 paragraph (a), clauses (5) to (15).

197.13 (c) Programs providing children's mental health crisis admissions and stabilization under  
197.14 section 245.4882, subdivision 6, are eligible vendors of room and board.

197.15 (d) Programs providing children's residential services under section 245.4882, except  
197.16 services for individuals who have a placement under chapter 260C or 260D, are eligible  
197.17 vendors of room and board.

197.18 (e) Licensed programs providing intensive residential treatment services or residential  
197.19 crisis stabilization services pursuant to section ~~256B.0622~~ or 256B.0624 or 256B.0632 are  
197.20 eligible vendors of room and board and are exempt from paragraph (a), clauses (6) to (15).

197.21 (f) A vendor that is not licensed as a residential treatment program must have a policy  
197.22 to address staffing coverage when a client may unexpectedly need to be present at the room  
197.23 and board site.

197.24 Sec. 6. Minnesota Statutes 2024, section 256.478, subdivision 2, is amended to read:

197.25 Subd. 2. **Eligibility.** An individual is eligible for the transition to community initiative  
197.26 if the individual can demonstrate that current services are not capable of meeting individual  
197.27 treatment and service needs that can be met in the community with support, and the individual  
197.28 meets at least one of the following criteria:

197.29 (1) the person meets the criteria under section 256B.092, subdivision 13, or 256B.49,  
197.30 subdivision 24;

198.1 (2) the person has met treatment objectives and no longer requires a hospital-level care,  
198.2 residential-level care, or a secure treatment setting, but the person's discharge from the  
198.3 Anoka Metro Regional Treatment Center, the Minnesota Forensic Mental Health Program,  
198.4 the Child and Adolescent Behavioral Health Hospital program, a psychiatric residential  
198.5 treatment facility under section 256B.0941, intensive residential treatment services under  
198.6 section ~~256B.0622~~ 256B.0632, children's residential services under section 245.4882,  
198.7 juvenile detention facility, county supervised building, or a hospital would be substantially  
198.8 delayed without additional resources available through the transitions to community initiative;

198.9 (3) the person (i) is receiving customized living services reimbursed under section  
198.10 256B.4914, 24-hour customized living services reimbursed under section 256B.4914, or  
198.11 community residential services reimbursed under section 256B.4914; (ii) expresses a desire  
198.12 to move; and (iii) has received approval from the commissioner; or

198.13 (4) the person can demonstrate that the person's needs are beyond the scope of current  
198.14 service designs and grant funding can support the inclusion of additional supports for the  
198.15 person to access appropriate treatment and services in the least restrictive environment.

198.16 Sec. 7. Minnesota Statutes 2024, section 256B.0615, subdivision 1, is amended to read:

198.17 Subdivision 1. **Scope.** Medical assistance covers mental health certified peer specialist  
198.18 services, as established in subdivision 2, if provided to recipients who are eligible for services  
198.19 under sections 256B.0622, 256B.0623, ~~and 256B.0624~~, and 256B.0632 and are provided  
198.20 by a mental health certified peer specialist who has completed the training under subdivision  
198.21 5 and is qualified according to section 245I.04, subdivision 10.

198.22 Sec. 8. Minnesota Statutes 2024, section 256B.0615, subdivision 3, is amended to read:

198.23 Subd. 3. **Eligibility.** Peer support services may be made available to consumers of (1)  
198.24 intensive residential treatment services under section ~~256B.0622~~ 256B.0632; (2) adult  
198.25 rehabilitative mental health services under section 256B.0623; and (3) crisis stabilization  
198.26 and mental health mobile crisis intervention services under section 256B.0624.

198.27 Sec. 9. Minnesota Statutes 2024, section 256B.82, is amended to read:

198.28 **256B.82 PREPAID PLANS AND MENTAL HEALTH REHABILITATIVE**  
198.29 **SERVICES.**

198.30 Medical assistance and MinnesotaCare prepaid health plans may include coverage for  
198.31 adult mental health rehabilitative services under section 256B.0623, intensive rehabilitative

199.1 services under section ~~256B.0622~~ 256B.0632, and adult mental health crisis response services  
199.2 under section 256B.0624, beginning January 1, 2005.

199.3 By January 15, 2004, the commissioner shall report to the legislature how these services  
199.4 should be included in prepaid plans. The commissioner shall consult with mental health  
199.5 advocates, health plans, and counties in developing this report. The report recommendations  
199.6 must include a plan to ensure coordination of these services between health plans and  
199.7 counties, assure recipient access to essential community providers, and monitor the health  
199.8 plans' delivery of services through utilization review and quality standards.

199.9 Sec. 10. Minnesota Statutes 2024, section 256D.44, subdivision 5, is amended to read:

199.10 Subd. 5. **Special needs.** (a) In addition to the state standards of assistance established  
199.11 in subdivisions 1 to 4, payments are allowed for the following special needs of recipients  
199.12 of Minnesota supplemental aid who are not residents of a nursing home, a regional treatment  
199.13 center, or a setting authorized to receive housing support payments under chapter 256I.

199.14 (b) The county agency shall pay a monthly allowance for medically prescribed diets if  
199.15 the cost of those additional dietary needs cannot be met through some other maintenance  
199.16 benefit. The need for special diets or dietary items must be prescribed by a licensed physician,  
199.17 advanced practice registered nurse, or physician assistant. Costs for special diets shall be  
199.18 determined as percentages of the allotment for a one-person household under the thrifty  
199.19 food plan as defined by the United States Department of Agriculture. The types of diets and  
199.20 the percentages of the thrifty food plan that are covered are as follows:

199.21 (1) high protein diet, at least 80 grams daily, 25 percent of thrifty food plan;

199.22 (2) controlled protein diet, 40 to 60 grams and requires special products, 100 percent of  
199.23 thrifty food plan;

199.24 (3) controlled protein diet, less than 40 grams and requires special products, 125 percent  
199.25 of thrifty food plan;

199.26 (4) low cholesterol diet, 25 percent of thrifty food plan;

199.27 (5) high residue diet, 20 percent of thrifty food plan;

199.28 (6) pregnancy and lactation diet, 35 percent of thrifty food plan;

199.29 (7) gluten-free diet, 25 percent of thrifty food plan;

199.30 (8) lactose-free diet, 25 percent of thrifty food plan;

199.31 (9) antidumping diet, 15 percent of thrifty food plan;

200.1 (10) hypoglycemic diet, 15 percent of thrifty food plan; or

200.2 (11) ketogenic diet, 25 percent of thrifty food plan.

200.3 (c) Payment for nonrecurring special needs must be allowed for necessary home repairs  
200.4 or necessary repairs or replacement of household furniture and appliances using the payment  
200.5 standard of the AFDC program in effect on July 16, 1996, for these expenses, as long as  
200.6 other funding sources are not available.

200.7 (d) A fee for guardian or conservator service is allowed at a reasonable rate negotiated  
200.8 by the county or approved by the court. This rate shall not exceed five percent of the  
200.9 assistance unit's gross monthly income up to a maximum of \$100 per month. If the guardian  
200.10 or conservator is a member of the county agency staff, no fee is allowed.

200.11 (e) The county agency shall continue to pay a monthly allowance of \$68 for restaurant  
200.12 meals for a person who was receiving a restaurant meal allowance on June 1, 1990, and  
200.13 who eats two or more meals in a restaurant daily. The allowance must continue until the  
200.14 person has not received Minnesota supplemental aid for one full calendar month or until  
200.15 the person's living arrangement changes and the person no longer meets the criteria for the  
200.16 restaurant meal allowance, whichever occurs first.

200.17 (f) A fee equal to the maximum monthly amount allowed by the Social Security  
200.18 Administration is allowed for representative payee services provided by an agency that  
200.19 meets the requirements under SSI regulations to charge a fee for representative payee  
200.20 services. This special need is available to all recipients of Minnesota supplemental aid  
200.21 regardless of their living arrangement.

200.22 (g)(1) Notwithstanding the language in this subdivision, an amount equal to one-half of  
200.23 the maximum federal Supplemental Security Income payment amount for a single individual  
200.24 which is in effect on the first day of July of each year will be added to the standards of  
200.25 assistance established in subdivisions 1 to 4 for adults under the age of 65 who qualify as  
200.26 in need of housing assistance and are:

200.27 (i) relocating from an institution, a setting authorized to receive housing support under  
200.28 chapter 256I, or an adult mental health residential treatment program under section ~~256B.0622~~  
200.29 256B.0632;

200.30 (ii) eligible for personal care assistance under section 256B.0659; or

200.31 (iii) home and community-based waiver recipients living in their own home or rented  
200.32 or leased apartment.

201.1 (2) Notwithstanding subdivision 3, paragraph (c), an individual eligible for the shelter  
201.2 needy benefit under this paragraph is considered a household of one. An eligible individual  
201.3 who receives this benefit prior to age 65 may continue to receive the benefit after the age  
201.4 of 65.

201.5 (3) "Housing assistance" means that the assistance unit incurs monthly shelter costs that  
201.6 exceed 40 percent of the assistance unit's gross income before the application of this special  
201.7 needs standard. "Gross income" for the purposes of this section is the applicant's or recipient's  
201.8 income as defined in section 256D.35, subdivision 10, or the standard specified in subdivision  
201.9 3, paragraph (a) or (b), whichever is greater. A recipient of a federal or state housing subsidy,  
201.10 that limits shelter costs to a percentage of gross income, shall not be considered in need of  
201.11 housing assistance for purposes of this paragraph.

## 201.12 ARTICLE 8

### 201.13 CHILDREN'S MENTAL HEALTH TERMINOLOGY

201.14 Section 1. Minnesota Statutes 2024, section 62Q.527, subdivision 1, is amended to read:

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

201.17 ~~(b) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.~~

201.18 ~~(e)~~ (b) "Mental illness" has the meaning given in ~~section~~ sections 245.462, subdivision  
201.19 20, paragraph (a), and 245.4871, subdivision 15.

201.20 ~~(d)~~ (c) "Health plan" has the meaning given in section 62Q.01, subdivision 3, but includes  
201.21 the coverages described in section 62A.011, subdivision 3, clauses (7) and (10).

201.22 Sec. 2. Minnesota Statutes 2024, section 62Q.527, subdivision 2, is amended to read:

201.23 Subd. 2. **Required coverage for antipsychotic drugs.** (a) A health plan that provides  
201.24 prescription drug coverage must provide coverage for an antipsychotic drug prescribed to  
201.25 treat ~~emotional disturbance or~~ mental illness regardless of whether the drug is in the health  
201.26 plan's drug formulary, if the health care provider prescribing the drug:

201.27 (1) indicates to the dispensing pharmacist, orally or in writing according to section  
201.28 151.21, that the prescription must be dispensed as communicated; and

201.29 (2) certifies in writing to the health plan company that the health care provider has  
201.30 considered all equivalent drugs in the health plan's drug formulary and has determined that  
201.31 the drug prescribed will best treat the patient's condition.

202.1 (b) The health plan is not required to provide coverage for a drug if the drug was removed  
202.2 from the health plan's drug formulary for safety reasons.

202.3 (c) For drugs covered under this section, no health plan company that has received a  
202.4 certification from the health care provider as described in paragraph (a) may:

202.5 (1) impose a special deductible, co-payment, coinsurance, or other special payment  
202.6 requirement that the health plan does not apply to drugs that are in the health plan's drug  
202.7 formulary; or

202.8 (2) require written certification from the prescribing provider each time a prescription  
202.9 is refilled or renewed that the drug prescribed will best treat the patient's condition.

202.10 Sec. 3. Minnesota Statutes 2024, section 62Q.527, subdivision 3, is amended to read:

202.11 Subd. 3. **Continuing care.** (a) Enrollees receiving a prescribed drug to treat a diagnosed  
202.12 mental illness ~~or emotional disturbance~~ may continue to receive the prescribed drug for up  
202.13 to one year without the imposition of a special deductible, co-payment, coinsurance, or  
202.14 other special payment requirements, when a health plan's drug formulary changes or an  
202.15 enrollee changes health plans and the medication has been shown to effectively treat the  
202.16 patient's condition. In order to be eligible for this continuing care benefit:

202.17 (1) the patient must have been treated with the drug for 90 days prior to a change in a  
202.18 health plan's drug formulary or a change in the enrollee's health plan;

202.19 (2) the health care provider prescribing the drug indicates to the dispensing pharmacist,  
202.20 orally or in writing according to section 151.21, that the prescription must be dispensed as  
202.21 communicated; and

202.22 (3) the health care provider prescribing the drug certifies in writing to the health plan  
202.23 company that the drug prescribed will best treat the patient's condition.

202.24 (b) The continuing care benefit shall be extended annually when the health care provider  
202.25 prescribing the drug:

202.26 (1) indicates to the dispensing pharmacist, orally or in writing according to section  
202.27 151.21, that the prescription must be dispensed as communicated; and

202.28 (2) certifies in writing to the health plan company that the drug prescribed will best treat  
202.29 the patient's condition.

202.30 (c) The health plan company is not required to provide coverage for a drug if the drug  
202.31 was removed from the health plan's drug formulary for safety reasons.

203.1 Sec. 4. Minnesota Statutes 2024, section 121A.61, subdivision 3, is amended to read:

203.2 Subd. 3. **Policy components.** The policy must include at least the following components:

203.3 (a) rules governing student conduct and procedures for informing students of the rules;

203.4 (b) the grounds for removal of a student from a class;

203.5 (c) the authority of the classroom teacher to remove students from the classroom pursuant

203.6 to procedures and rules established in the district's policy;

203.7 (d) the procedures for removal of a student from a class by a teacher, school administrator,

203.8 or other school district employee;

203.9 (e) the period of time for which a student may be removed from a class, which may not

203.10 exceed five class periods for a violation of a rule of conduct;

203.11 (f) provisions relating to the responsibility for and custody of a student removed from

203.12 a class;

203.13 (g) the procedures for return of a student to the specified class from which the student

203.14 has been removed;

203.15 (h) the procedures for notifying a student and the student's parents or guardian of

203.16 violations of the rules of conduct and of resulting disciplinary actions;

203.17 (i) any procedures determined appropriate for encouraging early involvement of parents

203.18 or guardians in attempts to improve a student's behavior;

203.19 (j) any procedures determined appropriate for encouraging early detection of behavioral

203.20 problems;

203.21 (k) any procedures determined appropriate for referring a student in need of special

203.22 education services to those services;

203.23 (l) any procedures determined appropriate for ensuring victims of bullying who respond

203.24 with behavior not allowed under the school's behavior policies have access to a remedial

203.25 response, consistent with section 121A.031;

203.26 (m) the procedures for consideration of whether there is a need for a further assessment

203.27 or of whether there is a need for a review of the adequacy of a current individualized

203.28 education program of a student with a disability who is removed from class;

203.29 (n) procedures for detecting and addressing chemical abuse problems of a student while

203.30 on the school premises;

203.31 (o) the minimum consequences for violations of the code of conduct;

204.1 (p) procedures for immediate and appropriate interventions tied to violations of the code;

204.2 (q) a provision that states that a teacher, school employee, school bus driver, or other  
204.3 agent of a district may use reasonable force in compliance with section 121A.582 and other  
204.4 laws;

204.5 (r) an agreement regarding procedures to coordinate crisis services to the extent funds  
204.6 are available with the county board responsible for implementing sections 245.487 to  
204.7 245.4889 for students with a serious ~~emotional disturbance~~ mental illness or other students  
204.8 who have an individualized education program whose behavior may be addressed by crisis  
204.9 intervention;

204.10 (s) a provision that states a student must be removed from class immediately if the student  
204.11 engages in assault or violent behavior. For purposes of this paragraph, "assault" has the  
204.12 meaning given it in section 609.02, subdivision 10. The removal shall be for a period of  
204.13 time deemed appropriate by the principal, in consultation with the teacher;

204.14 (t) a prohibition on the use of exclusionary practices for early learners as defined in  
204.15 section 121A.425; and

204.16 (u) a prohibition on the use of exclusionary practices to address attendance and truancy  
204.17 issues.

204.18 Sec. 5. Minnesota Statutes 2024, section 128C.02, subdivision 5, is amended to read:

204.19 Subd. 5. **Rules for open enrollees.** (a) The league shall adopt league rules and regulations  
204.20 governing the athletic participation of pupils attending school in a nonresident district under  
204.21 section 124D.03.

204.22 (b) Notwithstanding other law or league rule or regulation to the contrary, when a student  
204.23 enrolls in or is readmitted to a recovery-focused high school after successfully completing  
204.24 a licensed program for treatment of alcohol or substance abuse, or mental illness, ~~or emotional~~  
204.25 ~~disturbance~~, the student is immediately eligible to participate on the same basis as other  
204.26 district students in the league-sponsored activities of the student's resident school district.  
204.27 Nothing in this paragraph prohibits the league or school district from enforcing a league or  
204.28 district penalty resulting from the student violating a league or district rule.

204.29 (c) The league shall adopt league rules making a student with an individualized education  
204.30 program who transfers from one public school to another public school as a reasonable  
204.31 accommodation to reduce barriers to educational access immediately eligible to participate  
204.32 in league-sponsored varsity competition on the same basis as other students in the school  
204.33 to which the student transfers. The league also must establish guidelines, consistent with

205.1 this paragraph, for reviewing the 504 plan of a student who transfers between public schools  
205.2 to determine whether the student is immediately eligible to participate in league-sponsored  
205.3 varsity competition on the same basis as other students in the school to which the student  
205.4 transfers.

205.5 Sec. 6. Minnesota Statutes 2024, section 142G.02, subdivision 56, is amended to read:

205.6 Subd. 56. **Learning disabled.** "Learning disabled," for purposes of an extension to the  
205.7 60-month time limit under section 142G.42, subdivision 4, clause (3), means the person has  
205.8 a disorder in one or more of the psychological processes involved in perceiving,  
205.9 understanding, or using concepts through verbal language or nonverbal means. Learning  
205.10 disabled does not include learning problems that are primarily the result of visual, hearing,  
205.11 or motor disabilities; developmental disability; ~~emotional disturbance~~; or mental illness or  
205.12 due to environmental, cultural, or economic disadvantage.

205.13 Sec. 7. Minnesota Statutes 2024, section 142G.27, subdivision 4, is amended to read:

205.14 Subd. 4. **Good cause exemptions for not attending orientation.** (a) The county agency  
205.15 shall not impose the sanction under section 142G.70 if it determines that the participant has  
205.16 good cause for failing to attend orientation. Good cause exists when:

205.17 (1) appropriate child care is not available;

205.18 (2) the participant is ill or injured;

205.19 (3) a family member is ill and needs care by the participant that prevents the participant  
205.20 from attending orientation. For a caregiver with a child or adult in the household who meets  
205.21 the disability or medical criteria for home care services under section 256B.0659, or a home  
205.22 and community-based waiver services program under chapter 256B, or meets the criteria  
205.23 for ~~severe emotional disturbance~~ serious mental illness under section 245.4871, subdivision  
205.24 6, or for serious and persistent mental illness under section 245.462, subdivision 20,  
205.25 paragraph (c), good cause also exists when an interruption in the provision of those services  
205.26 occurs which prevents the participant from attending orientation;

205.27 (4) the caregiver is unable to secure necessary transportation;

205.28 (5) the caregiver is in an emergency situation that prevents orientation attendance;

205.29 (6) the orientation conflicts with the caregiver's work, training, or school schedule; or

205.30 (7) the caregiver documents other verifiable impediments to orientation attendance  
205.31 beyond the caregiver's control.

206.1 (b) Counties must work with clients to provide child care and transportation necessary  
206.2 to ensure a caregiver has every opportunity to attend orientation.

206.3 Sec. 8. Minnesota Statutes 2024, section 142G.42, subdivision 3, is amended to read:

206.4 Subd. 3. **III or incapacitated.** (a) An assistance unit subject to the time limit in section  
206.5 142G.40, subdivision 1, is eligible to receive months of assistance under a hardship extension  
206.6 if the participant who reached the time limit belongs to any of the following groups:

206.7 (1) participants who are suffering from an illness, injury, or incapacity which has been  
206.8 certified by a qualified professional when the illness, injury, or incapacity is expected to  
206.9 continue for more than 30 days and severely limits the person's ability to obtain or maintain  
206.10 suitable employment. These participants must follow the treatment recommendations of the  
206.11 qualified professional certifying the illness, injury, or incapacity;

206.12 (2) participants whose presence in the home is required as a caregiver because of the  
206.13 illness, injury, or incapacity of another member in the assistance unit, a relative in the  
206.14 household, or a foster child in the household when the illness or incapacity and the need  
206.15 for a person to provide assistance in the home has been certified by a qualified professional  
206.16 and is expected to continue for more than 30 days; or

206.17 (3) caregivers with a child or an adult in the household who meets the disability or  
206.18 medical criteria for home care services under section 256B.0651, subdivision 1, paragraph  
206.19 (c), or a home and community-based waiver services program under chapter 256B, or meets  
206.20 the criteria for ~~severe emotional disturbance~~ serious mental illness under section 245.4871,  
206.21 subdivision 6, or for serious and persistent mental illness under section 245.462, subdivision  
206.22 20, paragraph (c). Caregivers in this category are presumed to be prevented from obtaining  
206.23 or maintaining suitable employment.

206.24 (b) An assistance unit receiving assistance under a hardship extension under this  
206.25 subdivision may continue to receive assistance as long as the participant meets the criteria  
206.26 in paragraph (a), clause (1), (2), or (3).

206.27 Sec. 9. Minnesota Statutes 2024, section 245.462, subdivision 4, is amended to read:

206.28 Subd. 4. **Case management service provider.** (a) "Case management service provider"  
206.29 means a case manager or case manager associate employed by the county or other entity  
206.30 authorized by the county board to provide case management services specified in section  
206.31 245.4711.

206.32 (b) A case manager must:

207.1 (1) be skilled in the process of identifying and assessing a wide range of client needs;

207.2 (2) be knowledgeable about local community resources and how to use those resources  
207.3 for the benefit of the client;

207.4 (3) be a mental health practitioner as defined in section 245I.04, subdivision 4, or have  
207.5 a bachelor's degree in one of the behavioral sciences or related fields including, but not  
207.6 limited to, social work, psychology, or nursing from an accredited college or university. A  
207.7 case manager who is not a mental health practitioner and who does not have a bachelor's  
207.8 degree in one of the behavioral sciences or related fields must meet the requirements of  
207.9 paragraph (c); and

207.10 (4) meet the supervision and continuing education requirements described in paragraphs  
207.11 (d), (e), and (f), as applicable.

207.12 (c) Case managers without a bachelor's degree must meet one of the requirements in  
207.13 clauses (1) to (3):

207.14 (1) have three or four years of experience as a case manager associate as defined in this  
207.15 section;

207.16 (2) be a registered nurse without a bachelor's degree and have a combination of  
207.17 specialized training in psychiatry and work experience consisting of community interaction  
207.18 and involvement or community discharge planning in a mental health setting totaling three  
207.19 years; or

207.20 (3) be a person who qualified as a case manager under the 1998 Department of Human  
207.21 Service waiver provision and meet the continuing education and mentoring requirements  
207.22 in this section.

207.23 (d) A case manager with at least 2,000 hours of supervised experience in the delivery  
207.24 of services to adults with mental illness must receive regular ongoing supervision and clinical  
207.25 supervision totaling 38 hours per year of which at least one hour per month must be clinical  
207.26 supervision regarding individual service delivery with a case management supervisor. The  
207.27 remaining 26 hours of supervision may be provided by a case manager with two years of  
207.28 experience. Group supervision may not constitute more than one-half of the required  
207.29 supervision hours. Clinical supervision must be documented in the client record.

207.30 (e) A case manager without 2,000 hours of supervised experience in the delivery of  
207.31 services to adults with mental illness must:

208.1 (1) receive clinical supervision regarding individual service delivery from a mental  
208.2 health professional at least one hour per week until the requirement of 2,000 hours of  
208.3 experience is met; and

208.4 (2) complete 40 hours of training approved by the commissioner in case management  
208.5 skills and the characteristics and needs of adults with serious and persistent mental illness.

208.6 (f) A case manager who is not licensed, registered, or certified by a health-related  
208.7 licensing board must receive 30 hours of continuing education and training in mental illness  
208.8 and mental health services every two years.

208.9 (g) A case manager associate (CMA) must:

208.10 (1) work under the direction of a case manager or case management supervisor;

208.11 (2) be at least 21 years of age;

208.12 (3) have at least a high school diploma or its equivalent; and

208.13 (4) meet one of the following criteria:

208.14 (i) have an associate of arts degree in one of the behavioral sciences or human services;

208.15 (ii) be a certified peer specialist under section 256B.0615;

208.16 (iii) be a registered nurse without a bachelor's degree;

208.17 (iv) within the previous ten years, have three years of life experience with serious and  
208.18 persistent mental illness as defined in subdivision 20; ~~or as a child had severe emotional~~  
208.19 ~~disturbance~~ a serious mental illness as defined in section 245.4871, subdivision 6; or have  
208.20 three years life experience as a primary caregiver to an adult with serious and persistent  
208.21 mental illness within the previous ten years;

208.22 (v) have 6,000 hours work experience as a nondegreed state hospital technician; or

208.23 (vi) have at least 6,000 hours of supervised experience in the delivery of services to  
208.24 persons with mental illness.

208.25 Individuals meeting one of the criteria in items (i) to (v) may qualify as a case manager  
208.26 after four years of supervised work experience as a case manager associate. Individuals  
208.27 meeting the criteria in item (vi) may qualify as a case manager after three years of supervised  
208.28 experience as a case manager associate.

208.29 (h) A case management associate must meet the following supervision, mentoring, and  
208.30 continuing education requirements:

208.31 (1) have 40 hours of preservice training described under paragraph (e), clause (2);

209.1 (2) receive at least 40 hours of continuing education in mental illness and mental health  
209.2 services annually; and

209.3 (3) receive at least five hours of mentoring per week from a case management mentor.

209.4 A "case management mentor" means a qualified, practicing case manager or case management  
209.5 supervisor who teaches or advises and provides intensive training and clinical supervision  
209.6 to one or more case manager associates. Mentoring may occur while providing direct services  
209.7 to consumers in the office or in the field and may be provided to individuals or groups of  
209.8 case manager associates. At least two mentoring hours per week must be individual and  
209.9 face-to-face.

209.10 (i) A case management supervisor must meet the criteria for mental health professionals,  
209.11 as specified in subdivision 18.

209.12 (j) An immigrant who does not have the qualifications specified in this subdivision may  
209.13 provide case management services to adult immigrants with serious and persistent mental  
209.14 illness who are members of the same ethnic group as the case manager if the person:

209.15 (1) is currently enrolled in and is actively pursuing credits toward the completion of a  
209.16 bachelor's degree in one of the behavioral sciences or a related field including, but not  
209.17 limited to, social work, psychology, or nursing from an accredited college or university;

209.18 (2) completes 40 hours of training as specified in this subdivision; and

209.19 (3) receives clinical supervision at least once a week until the requirements of this  
209.20 subdivision are met.

209.21 Sec. 10. Minnesota Statutes 2024, section 245.4682, subdivision 3, is amended to read:

209.22 Subd. 3. **Projects for coordination of care.** (a) Consistent with section 256B.69 and  
209.23 chapter 256L, the commissioner is authorized to solicit, approve, and implement up to three  
209.24 projects to demonstrate the integration of physical and mental health services within prepaid  
209.25 health plans and their coordination with social services. The commissioner shall require  
209.26 that each project be based on locally defined partnerships that include at least one health  
209.27 maintenance organization, community integrated service network, or accountable provider  
209.28 network authorized and operating under chapter 62D, 62N, or 62T, or county-based  
209.29 purchasing entity under section 256B.692 that is eligible to contract with the commissioner  
209.30 as a prepaid health plan, and the county or counties within the service area. Counties shall  
209.31 retain responsibility and authority for social services in these locally defined partnerships.

210.1 (b) The commissioner, in consultation with consumers, families, and their representatives,  
210.2 shall:

210.3 (1) determine criteria for approving the projects and use those criteria to solicit proposals  
210.4 for preferred integrated networks. The commissioner must develop criteria to evaluate the  
210.5 partnership proposed by the county and prepaid health plan to coordinate access and delivery  
210.6 of services. The proposal must at a minimum address how the partnership will coordinate  
210.7 the provision of:

210.8 (i) client outreach and identification of health and social service needs paired with  
210.9 expedited access to appropriate resources;

210.10 (ii) activities to maintain continuity of health care coverage;

210.11 (iii) children's residential mental health treatment and treatment foster care;

210.12 (iv) court-ordered assessments and treatments;

210.13 (v) prepetition screening and commitments under chapter 253B;

210.14 (vi) assessment and treatment of children identified through mental health screening of  
210.15 child welfare and juvenile corrections cases;

210.16 (vii) home and community-based waiver services;

210.17 (viii) assistance with finding and maintaining employment;

210.18 (ix) housing; and

210.19 (x) transportation;

210.20 (2) determine specifications for contracts with prepaid health plans to improve the plan's  
210.21 ability to serve persons with mental health conditions, including specifications addressing:

210.22 (i) early identification and intervention of physical and behavioral health problems;

210.23 (ii) communication between the enrollee and the health plan;

210.24 (iii) facilitation of enrollment for persons who are also eligible for a Medicare special  
210.25 needs plan offered by the health plan;

210.26 (iv) risk screening procedures;

210.27 (v) health care coordination;

210.28 (vi) member services and access to applicable protections and appeal processes;

210.29 (vii) specialty provider networks;

- 211.1 (viii) transportation services;
- 211.2 (ix) treatment planning; and
- 211.3 (x) administrative simplification for providers;
- 211.4 (3) begin implementation of the projects no earlier than January 1, 2009, with not more
- 211.5 than 40 percent of the statewide population included during calendar year 2009 and additional
- 211.6 counties included in subsequent years;
- 211.7 (4) waive any administrative rule not consistent with the implementation of the projects;
- 211.8 (5) allow potential bidders at least 90 days to respond to the request for proposals; and
- 211.9 (6) conduct an independent evaluation to determine if mental health outcomes have
- 211.10 improved in that county or counties according to measurable standards designed in
- 211.11 consultation with the advisory body established under this subdivision and reviewed by the
- 211.12 State Advisory Council on Mental Health.
- 211.13 (c) Notwithstanding any statute or administrative rule to the contrary, the commissioner
- 211.14 may enroll all persons eligible for medical assistance with serious mental illness ~~or emotional~~
- 211.15 ~~disturbance~~ in the prepaid plan of their choice within the project service area unless:
- 211.16 (1) the individual is eligible for home and community-based services for persons with
- 211.17 developmental disabilities and related conditions under section 256B.092; or
- 211.18 (2) the individual has a basis for exclusion from the prepaid plan under section 256B.69,
- 211.19 subdivision 4, other than disability, or mental illness, ~~or emotional disturbance~~.
- 211.20 (d) The commissioner shall involve organizations representing persons with mental
- 211.21 illness and their families in the development and distribution of information used to educate
- 211.22 potential enrollees regarding their options for health care and mental health service delivery
- 211.23 under this subdivision.
- 211.24 (e) If the person described in paragraph (c) does not elect to remain in fee-for-service
- 211.25 medical assistance, or declines to choose a plan, the commissioner may preferentially assign
- 211.26 that person to the prepaid plan participating in the preferred integrated network. The
- 211.27 commissioner shall implement the enrollment changes within a project's service area on the
- 211.28 timeline specified in that project's approved application.
- 211.29 (f) A person enrolled in a prepaid health plan under paragraphs (c) and (d) may disenroll
- 211.30 from the plan at any time.
- 211.31 (g) The commissioner, in consultation with consumers, families, and their representatives,
- 211.32 shall evaluate the projects begun in 2009, and shall refine the design of the service integration

212.1 projects before expanding the projects. The commissioner shall report to the chairs of the  
212.2 legislative committees with jurisdiction over mental health services by March 1, 2008, on  
212.3 plans for evaluation of preferred integrated networks established under this subdivision.

212.4 (h) The commissioner shall apply for any federal waivers necessary to implement these  
212.5 changes.

212.6 (i) Payment for Medicaid service providers under this subdivision for the months of  
212.7 May and June will be made no earlier than July 1 of the same calendar year.

212.8 Sec. 11. Minnesota Statutes 2024, section 245.4835, subdivision 2, is amended to read:

212.9 Subd. 2. **Failure to maintain expenditures.** (a) If a county does not comply with  
212.10 subdivision 1, the commissioner shall require the county to develop a corrective action plan  
212.11 according to a format and timeline established by the commissioner. If the commissioner  
212.12 determines that a county has not developed an acceptable corrective action plan within the  
212.13 required timeline, or that the county is not in compliance with an approved corrective action  
212.14 plan, the protections provided to that county under section 245.485 do not apply.

212.15 (b) The commissioner shall consider the following factors to determine whether to  
212.16 approve a county's corrective action plan:

212.17 (1) the degree to which a county is maximizing revenues for mental health services from  
212.18 noncounty sources;

212.19 (2) the degree to which a county is expanding use of alternative services that meet mental  
212.20 health needs, but do not count as mental health services within existing reporting systems.  
212.21 If approved by the commissioner, the alternative services must be included in the county's  
212.22 base as well as subsequent years. The commissioner's approval for alternative services must  
212.23 be based on the following criteria:

212.24 (i) the service must be provided to children ~~with emotional disturbance~~ or adults with  
212.25 mental illness;

212.26 (ii) the services must be based on an individual treatment plan or individual community  
212.27 support plan as defined in the Comprehensive Mental Health Act; and

212.28 (iii) the services must be supervised by a mental health professional and provided by  
212.29 staff who meet the staff qualifications defined in sections 256B.0943, subdivision 7, and  
212.30 256B.0623, subdivision 5.

212.31 (c) Additional county expenditures to make up for the prior year's underspending may  
212.32 be spread out over a two-year period.

213.1 Sec. 12. Minnesota Statutes 2024, section 245.4863, is amended to read:

213.2 **245.4863 INTEGRATED CO-OCCURRING DISORDER TREATMENT.**

213.3 (a) The commissioner shall require individuals who perform substance use disorder  
213.4 assessments to screen clients for co-occurring mental health disorders, and staff who perform  
213.5 mental health diagnostic assessments to screen for co-occurring substance use disorders.  
213.6 Screening tools must be approved by the commissioner. If a client screens positive for a  
213.7 co-occurring mental health or substance use disorder, the individual performing the screening  
213.8 must document what actions will be taken in response to the results and whether further  
213.9 assessments must be performed.

213.10 (b) Notwithstanding paragraph (a), screening is not required when:

213.11 (1) the presence of co-occurring disorders was documented for the client in the past 12  
213.12 months;

213.13 (2) the client is currently receiving co-occurring disorders treatment;

213.14 (3) the client is being referred for co-occurring disorders treatment; or

213.15 (4) a mental health professional who is competent to perform diagnostic assessments of  
213.16 co-occurring disorders is performing a diagnostic assessment to identify whether the client  
213.17 may have co-occurring mental health and substance use disorders. If an individual is  
213.18 identified to have co-occurring mental health and substance use disorders, the assessing  
213.19 mental health professional must document what actions will be taken to address the client's  
213.20 co-occurring disorders.

213.21 (c) The commissioner shall adopt rules as necessary to implement this section. The  
213.22 commissioner shall ensure that the rules are effective on July 1, 2013, thereby establishing  
213.23 a certification process for integrated dual disorder treatment providers and a system through  
213.24 which individuals receive integrated dual diagnosis treatment if assessed as having both a  
213.25 substance use disorder and ~~either a serious mental illness or emotional disturbance.~~

213.26 (d) The commissioner shall apply for any federal waivers necessary to secure, to the  
213.27 extent allowed by law, federal financial participation for the provision of integrated dual  
213.28 diagnosis treatment to persons with co-occurring disorders.

213.29 Sec. 13. Minnesota Statutes 2024, section 245.487, subdivision 2, is amended to read:

213.30 Subd. 2. **Findings.** The legislature finds there is a need for further development of  
213.31 existing clinical services for ~~emotionally-disturbed~~ children with mental illness and their  
213.32 families and the creation of new services for this population. Although the services specified

214.1 in sections 245.487 to 245.4889 are mental health services, sections 245.487 to 245.4889  
214.2 emphasize the need for a child-oriented and family-oriented approach of therapeutic  
214.3 programming and the need for continuity of care with other community agencies. At the  
214.4 same time, sections 245.487 to 245.4889 emphasize the importance of developing special  
214.5 mental health expertise in children's mental health services because of the unique needs of  
214.6 this population.

214.7 Nothing in sections 245.487 to 245.4889 shall be construed to abridge the authority of  
214.8 the court to make dispositions under chapter 260, but the mental health services due any  
214.9 child with serious and persistent mental illness, as defined in section 245.462, subdivision  
214.10 20, or with ~~severe emotional disturbance~~ a serious mental illness, as defined in section  
214.11 245.4871, subdivision 6, shall be made a part of any disposition affecting that child.

214.12 Sec. 14. Minnesota Statutes 2024, section 245.4871, subdivision 3, is amended to read:

214.13 Subd. 3. **Case management services.** "Case management services" means activities  
214.14 that are coordinated with the family community support services and are designed to help  
214.15 the child with ~~severe emotional disturbance~~ serious mental illness and the child's family  
214.16 obtain needed mental health services, social services, educational services, health services,  
214.17 vocational services, recreational services, and related services in the areas of volunteer  
214.18 services, advocacy, transportation, and legal services. Case management services include  
214.19 assisting in obtaining a comprehensive diagnostic assessment, developing an individual  
214.20 family community support plan, and assisting the child and the child's family in obtaining  
214.21 needed services by coordination with other agencies and assuring continuity of care. Case  
214.22 managers must assess and reassess the delivery, appropriateness, and effectiveness of services  
214.23 over time.

214.24 Sec. 15. Minnesota Statutes 2024, section 245.4871, subdivision 4, is amended to read:

214.25 Subd. 4. **Case management service provider.** (a) "Case management service provider"  
214.26 means a case manager or case manager associate employed by the county or other entity  
214.27 authorized by the county board to provide case management services specified in subdivision  
214.28 3 for the child with ~~severe emotional disturbance~~ serious mental illness and the child's  
214.29 family.

214.30 (b) A case manager must:

214.31 (1) have experience and training in working with children;

215.1 (2) have at least a bachelor's degree in one of the behavioral sciences or a related field  
215.2 including, but not limited to, social work, psychology, or nursing from an accredited college  
215.3 or university or meet the requirements of paragraph (d);

215.4 (3) have experience and training in identifying and assessing a wide range of children's  
215.5 needs;

215.6 (4) be knowledgeable about local community resources and how to use those resources  
215.7 for the benefit of children and their families; and

215.8 (5) meet the supervision and continuing education requirements of paragraphs (e), (f),  
215.9 and (g), as applicable.

215.10 (c) A case manager may be a member of any professional discipline that is part of the  
215.11 local system of care for children established by the county board.

215.12 (d) A case manager without a bachelor's degree must meet one of the requirements in  
215.13 clauses (1) to (3):

215.14 (1) have three or four years of experience as a case manager associate;

215.15 (2) be a registered nurse without a bachelor's degree who has a combination of specialized  
215.16 training in psychiatry and work experience consisting of community interaction and  
215.17 involvement or community discharge planning in a mental health setting totaling three years;  
215.18 or

215.19 (3) be a person who qualified as a case manager under the 1998 Department of Human  
215.20 Services waiver provision and meets the continuing education, supervision, and mentoring  
215.21 requirements in this section.

215.22 (e) A case manager with at least 2,000 hours of supervised experience in the delivery  
215.23 of mental health services to children must receive regular ongoing supervision and clinical  
215.24 supervision totaling 38 hours per year, of which at least one hour per month must be clinical  
215.25 supervision regarding individual service delivery with a case management supervisor. The  
215.26 other 26 hours of supervision may be provided by a case manager with two years of  
215.27 experience. Group supervision may not constitute more than one-half of the required  
215.28 supervision hours.

215.29 (f) A case manager without 2,000 hours of supervised experience in the delivery of  
215.30 mental health services to children with ~~emotional disturbance~~ mental illness must:

215.31 (1) begin 40 hours of training approved by the commissioner of human services in case  
215.32 management skills and in the characteristics and needs of children with ~~severe emotional~~

216.1 ~~disturbance~~ serious mental illness before beginning to provide case management services;  
216.2 and

216.3 (2) receive clinical supervision regarding individual service delivery from a mental  
216.4 health professional at least one hour each week until the requirement of 2,000 hours of  
216.5 experience is met.

216.6 (g) A case manager who is not licensed, registered, or certified by a health-related  
216.7 licensing board must receive 30 hours of continuing education and training in ~~severe~~  
216.8 ~~emotional disturbance~~ serious mental illness and mental health services every two years.

216.9 (h) Clinical supervision must be documented in the child's record. When the case manager  
216.10 is not a mental health professional, the county board must provide or contract for needed  
216.11 clinical supervision.

216.12 (i) The county board must ensure that the case manager has the freedom to access and  
216.13 coordinate the services within the local system of care that are needed by the child.

216.14 (j) A case manager associate (CMA) must:

216.15 (1) work under the direction of a case manager or case management supervisor;

216.16 (2) be at least 21 years of age;

216.17 (3) have at least a high school diploma or its equivalent; and

216.18 (4) meet one of the following criteria:

216.19 (i) have an associate of arts degree in one of the behavioral sciences or human services;

216.20 (ii) be a registered nurse without a bachelor's degree;

216.21 (iii) have three years of life experience as a primary caregiver to a child with serious  
216.22 ~~emotional disturbance~~ mental illness as defined in subdivision 6 within the previous ten  
216.23 years;

216.24 (iv) have 6,000 hours work experience as a nondegreed state hospital technician; or

216.25 (v) have 6,000 hours of supervised work experience in the delivery of mental health  
216.26 services to children with ~~emotional disturbances~~ mental illness; hours worked as a mental  
216.27 health behavioral aide I or II under section 256B.0943, subdivision 7, may count toward  
216.28 the 6,000 hours of supervised work experience.

216.29 Individuals meeting one of the criteria in items (i) to (iv) may qualify as a case manager  
216.30 after four years of supervised work experience as a case manager associate. Individuals

217.1 meeting the criteria in item (v) may qualify as a case manager after three years of supervised  
217.2 experience as a case manager associate.

217.3 (k) Case manager associates must meet the following supervision, mentoring, and  
217.4 continuing education requirements;

217.5 (1) have 40 hours of preservice training described under paragraph (f), clause (1);

217.6 (2) receive at least 40 hours of continuing education in ~~severe emotional disturbance~~  
217.7 serious mental illness and mental health service annually; and

217.8 (3) receive at least five hours of mentoring per week from a case management mentor.

217.9 A "case management mentor" means a qualified, practicing case manager or case management  
217.10 supervisor who teaches or advises and provides intensive training and clinical supervision  
217.11 to one or more case manager associates. Mentoring may occur while providing direct services  
217.12 to consumers in the office or in the field and may be provided to individuals or groups of  
217.13 case manager associates. At least two mentoring hours per week must be individual and  
217.14 face-to-face.

217.15 (l) A case management supervisor must meet the criteria for a mental health professional  
217.16 as specified in subdivision 27.

217.17 (m) An immigrant who does not have the qualifications specified in this subdivision  
217.18 may provide case management services to child immigrants with ~~severe emotional~~  
217.19 ~~disturbance~~ serious mental illness of the same ethnic group as the immigrant if the person:

217.20 (1) is currently enrolled in and is actively pursuing credits toward the completion of a  
217.21 bachelor's degree in one of the behavioral sciences or related fields at an accredited college  
217.22 or university;

217.23 (2) completes 40 hours of training as specified in this subdivision; and

217.24 (3) receives clinical supervision at least once a week until the requirements of obtaining  
217.25 a bachelor's degree and 2,000 hours of supervised experience are met.

217.26 Sec. 16. Minnesota Statutes 2024, section 245.4871, subdivision 6, is amended to read:

217.27 Subd. 6. **Child with ~~severe emotional disturbance~~ serious mental illness.** For purposes  
217.28 of eligibility for case management and family community support services, "child with  
217.29 ~~severe emotional disturbance~~ serious mental illness" means a child who has ~~an emotional~~  
217.30 ~~disturbance~~ a mental illness and who meets one of the following criteria:

218.1 (1) the child has been admitted within the last three years or is at risk of being admitted  
218.2 to inpatient treatment or residential treatment for ~~an emotional disturbance~~ a mental illness;  
218.3 or

218.4 (2) the child is a Minnesota resident and is receiving inpatient treatment or residential  
218.5 treatment for ~~an emotional disturbance~~ a mental illness through the interstate compact; or

218.6 (3) the child has one of the following as determined by a mental health professional:

218.7 (i) psychosis or a clinical depression; or

218.8 (ii) risk of harming self or others as a result of ~~an emotional disturbance~~ a mental illness;

218.9 or

218.10 (iii) psychopathological symptoms as a result of being a victim of physical or sexual  
218.11 abuse or of psychic trauma within the past year; or

218.12 (4) the child, as a result of ~~an emotional disturbance~~ a mental illness, has significantly  
218.13 impaired home, school, or community functioning that has lasted at least one year or that,  
218.14 in the written opinion of a mental health professional, presents substantial risk of lasting at  
218.15 least one year.

218.16 Sec. 17. Minnesota Statutes 2024, section 245.4871, subdivision 13, is amended to read:

218.17 Subd. 13. **Education and prevention services.** (a) "Education and prevention services"  
218.18 means services designed to:

218.19 (1) educate the general public;

218.20 (2) increase the understanding and acceptance of problems associated with ~~emotional~~  
218.21 ~~disturbances~~ children's mental illnesses;

218.22 (3) improve people's skills in dealing with high-risk situations known to affect children's  
218.23 mental health and functioning; and

218.24 (4) refer specific children or their families with mental health needs to mental health  
218.25 services.

218.26 (b) The services include distribution to individuals and agencies identified by the county  
218.27 board and the local children's mental health advisory council of information on predictors  
218.28 and symptoms of ~~emotional disturbances~~ mental illnesses, where mental health services are  
218.29 available in the county, and how to access the services.

219.1 Sec. 18. Minnesota Statutes 2024, section 245.4871, subdivision 15, is amended to read:

219.2 Subd. 15. ~~Emotional disturbance~~ **Mental illness.** "~~Emotional disturbance~~" "Mental  
219.3 illness" means an organic disorder of the brain or a clinically significant disorder of thought,  
219.4 mood, perception, orientation, memory, or behavior that:

219.5 (1) is detailed in a diagnostic codes list published by the commissioner; and

219.6 (2) seriously limits a child's capacity to function in primary aspects of daily living such  
219.7 as personal relations, living arrangements, work, school, and recreation.

219.8 "~~Emotional disturbance~~" Mental illness is a generic term and is intended to reflect all  
219.9 categories of disorder described in the clinical code list published by the commissioner as  
219.10 "usually first evident in childhood or adolescence."

219.11 Sec. 19. Minnesota Statutes 2024, section 245.4871, subdivision 17, is amended to read:

219.12 Subd. 17. **Family community support services.** "Family community support services"  
219.13 means services provided under the treatment supervision of a mental health professional  
219.14 and designed to help each child with ~~severe emotional disturbance~~ serious mental illness to  
219.15 function and remain with the child's family in the community. Family community support  
219.16 services do not include acute care hospital inpatient treatment, residential treatment services,  
219.17 or regional treatment center services. Family community support services include:

219.18 (1) client outreach to each child with ~~severe emotional disturbance~~ serious mental illness  
219.19 and the child's family;

219.20 (2) medication monitoring where necessary;

219.21 (3) assistance in developing independent living skills;

219.22 (4) assistance in developing parenting skills necessary to address the needs of the child  
219.23 with ~~severe emotional disturbance~~ serious mental illness;

219.24 (5) assistance with leisure and recreational activities;

219.25 (6) crisis planning, including crisis placement and respite care;

219.26 (7) professional home-based family treatment;

219.27 (8) foster care with therapeutic supports;

219.28 (9) day treatment;

219.29 (10) assistance in locating respite care and special needs day care; and

220.1 (11) assistance in obtaining potential financial resources, including those benefits listed  
220.2 in section 245.4884, subdivision 5.

220.3 Sec. 20. Minnesota Statutes 2024, section 245.4871, subdivision 19, is amended to read:

220.4 Subd. 19. **Individual family community support plan.** "Individual family community  
220.5 support plan" means a written plan developed by a case manager in conjunction with the  
220.6 family and the child with ~~severe emotional disturbance~~ serious mental illness on the basis  
220.7 of a diagnostic assessment and a functional assessment. The plan identifies specific services  
220.8 needed by a child and the child's family to:

220.9 (1) treat the symptoms and dysfunctions determined in the diagnostic assessment;

220.10 (2) relieve conditions leading to ~~emotional disturbance~~ mental illness and improve the  
220.11 personal well-being of the child;

220.12 (3) improve family functioning;

220.13 (4) enhance daily living skills;

220.14 (5) improve functioning in education and recreation settings;

220.15 (6) improve interpersonal and family relationships;

220.16 (7) enhance vocational development; and

220.17 (8) assist in obtaining transportation, housing, health services, and employment.

220.18 Sec. 21. Minnesota Statutes 2024, section 245.4871, subdivision 21, is amended to read:

220.19 Subd. 21. **Individual treatment plan.** (a) "Individual treatment plan" means the  
220.20 formulation of planned services that are responsive to the needs and goals of a client. An  
220.21 individual treatment plan must be completed according to section 245I.10, subdivisions 7  
220.22 and 8.

220.23 (b) A children's residential facility licensed under Minnesota Rules, chapter 2960, is  
220.24 exempt from the requirements of section 245I.10, subdivisions 7 and 8. Instead, the individual  
220.25 treatment plan must:

220.26 (1) include a written plan of intervention, treatment, and services for a child with ~~an~~  
220.27 ~~emotional disturbance~~ a mental illness that the service provider develops under the clinical  
220.28 supervision of a mental health professional on the basis of a diagnostic assessment;

220.29 (2) be developed in conjunction with the family unless clinically inappropriate; and

221.1 (3) identify goals and objectives of treatment, treatment strategy, a schedule for  
221.2 accomplishing treatment goals and objectives, and the individuals responsible for providing  
221.3 treatment to the child with ~~an emotional disturbance~~ a mental illness.

221.4 Sec. 22. Minnesota Statutes 2024, section 245.4871, subdivision 22, is amended to read:

221.5 Subd. 22. **Legal representative.** "Legal representative" means a guardian, conservator,  
221.6 or guardian ad litem of a child with ~~an emotional disturbance~~ a mental illness authorized  
221.7 by the court to make decisions about mental health services for the child.

221.8 Sec. 23. Minnesota Statutes 2024, section 245.4871, subdivision 28, is amended to read:

221.9 Subd. 28. **Mental health services.** "Mental health services" means at least all of the  
221.10 treatment services and case management activities that are provided to children with  
221.11 ~~emotional disturbances~~ mental illnesses and are described in sections 245.487 to 245.4889.

221.12 Sec. 24. Minnesota Statutes 2024, section 245.4871, subdivision 29, is amended to read:

221.13 Subd. 29. **Outpatient services.** "Outpatient services" means mental health services,  
221.14 excluding day treatment and community support services programs, provided by or under  
221.15 the treatment supervision of a mental health professional to children with ~~emotional~~  
221.16 ~~disturbances~~ mental illnesses who live outside a hospital. Outpatient services include clinical  
221.17 activities such as individual, group, and family therapy; individual treatment planning;  
221.18 diagnostic assessments; medication management; and psychological testing.

221.19 Sec. 25. Minnesota Statutes 2024, section 245.4871, subdivision 32, is amended to read:

221.20 Subd. 32. **Residential treatment.** "Residential treatment" means a 24-hour-a-day program  
221.21 under the treatment supervision of a mental health professional, in a community residential  
221.22 setting other than an acute care hospital or regional treatment center inpatient unit, that must  
221.23 be licensed as a residential treatment program for children with ~~emotional disturbances~~  
221.24 mental illnesses under Minnesota Rules, parts 2960.0580 to 2960.0700, or other rules adopted  
221.25 by the commissioner.

221.26 Sec. 26. Minnesota Statutes 2024, section 245.4871, subdivision 34, is amended to read:

221.27 Subd. 34. **Therapeutic support of foster care.** "Therapeutic support of foster care"  
221.28 means the mental health training and mental health support services and treatment supervision  
221.29 provided by a mental health professional to foster families caring for children with ~~severe~~  
221.30 ~~emotional disturbance~~ serious mental illnesses to provide a therapeutic family environment

222.1 and support for the child's improved functioning. Therapeutic support of foster care includes  
222.2 services provided under section 256B.0946.

222.3 Sec. 27. Minnesota Statutes 2024, section 245.4873, subdivision 2, is amended to read:

222.4 Subd. 2. **State level; coordination.** The Children's Cabinet, under section 4.045, in  
222.5 consultation with a representative of the Minnesota District Judges Association Juvenile  
222.6 Committee, shall:

222.7 (1) educate each agency about the policies, procedures, funding, and services for children  
222.8 with ~~emotional disturbances~~ mental illnesses of all agencies represented;

222.9 (2) develop mechanisms for interagency coordination on behalf of children with ~~emotional~~  
222.10 ~~disturbances~~ mental illnesses;

222.11 (3) identify barriers including policies and procedures within all agencies represented  
222.12 that interfere with delivery of mental health services for children;

222.13 (4) recommend policy and procedural changes needed to improve development and  
222.14 delivery of mental health services for children in the agency or agencies they represent; and

222.15 (5) identify mechanisms for better use of federal and state funding in the delivery of  
222.16 mental health services for children.

222.17 Sec. 28. Minnesota Statutes 2024, section 245.4875, subdivision 5, is amended to read:

222.18 Subd. 5. **Local children's advisory council.** (a) By October 1, 1989, the county board,  
222.19 individually or in conjunction with other county boards, shall establish a local children's  
222.20 mental health advisory council or children's mental health subcommittee of the existing  
222.21 local mental health advisory council or shall include persons on its existing mental health  
222.22 advisory council who are representatives of children's mental health interests. The following  
222.23 individuals must serve on the local children's mental health advisory council, the children's  
222.24 mental health subcommittee of an existing local mental health advisory council, or be  
222.25 included on an existing mental health advisory council: (1) at least one person who was in  
222.26 a mental health program as a child or adolescent; (2) at least one parent of a child or  
222.27 adolescent with ~~severe emotional disturbance~~ serious mental illness; (3) one children's  
222.28 mental health professional; (4) representatives of minority populations of significant size  
222.29 residing in the county; (5) a representative of the children's mental health local coordinating  
222.30 council; and (6) one family community support services program representative.

222.31 (b) The local children's mental health advisory council or children's mental health  
222.32 subcommittee of an existing advisory council shall seek input from parents, former

223.1 consumers, providers, and others about the needs of children with ~~emotional disturbance~~  
223.2 mental illness in the local area and services needed by families of these children, and shall  
223.3 meet monthly, unless otherwise determined by the council or subcommittee, but not less  
223.4 than quarterly, to review, evaluate, and make recommendations regarding the local children's  
223.5 mental health system. Annually, the local children's mental health advisory council or  
223.6 children's mental health subcommittee of the existing local mental health advisory council  
223.7 shall:

223.8 (1) arrange for input from the local system of care providers regarding coordination of  
223.9 care between the services;

223.10 (2) identify for the county board the individuals, providers, agencies, and associations  
223.11 as specified in section 245.4877, clause (2); and

223.12 (3) provide to the county board a report of unmet mental health needs of children residing  
223.13 in the county.

223.14 (c) The county board shall consider the advice of its local children's mental health  
223.15 advisory council or children's mental health subcommittee of the existing local mental health  
223.16 advisory council in carrying out its authorities and responsibilities.

223.17 Sec. 29. Minnesota Statutes 2024, section 245.4876, subdivision 4, is amended to read:

223.18 Subd. 4. **Referral for case management.** Each provider of emergency services, outpatient  
223.19 treatment, community support services, family community support services, day treatment  
223.20 services, screening under section 245.4885, professional home-based family treatment  
223.21 services, residential treatment facilities, acute care hospital inpatient treatment facilities, or  
223.22 regional treatment center services must inform each child with ~~severe emotional disturbance~~  
223.23 serious mental illness, and the child's parent or legal representative, of the availability and  
223.24 potential benefits to the child of case management. The information shall be provided as  
223.25 specified in subdivision 5. If consent is obtained according to subdivision 5, the provider  
223.26 must refer the child by notifying the county employee designated by the county board to  
223.27 coordinate case management activities of the child's name and address and by informing  
223.28 the child's family of whom to contact to request case management. The provider must  
223.29 document compliance with this subdivision in the child's record. The parent or child may  
223.30 directly request case management even if there has been no referral.

224.1 Sec. 30. Minnesota Statutes 2024, section 245.4876, subdivision 5, is amended to read:

224.2 Subd. 5. **Consent for services or for release of information.** (a) Although sections  
224.3 245.487 to 245.4889 require each county board, within the limits of available resources, to  
224.4 make the mental health services listed in those sections available to each child residing in  
224.5 the county who needs them, the county board shall not provide any services, either directly  
224.6 or by contract, unless consent to the services is obtained under this subdivision. The case  
224.7 manager assigned to a child with a ~~severe emotional disturbance~~ serious mental illness shall  
224.8 not disclose to any person other than the case manager's immediate supervisor and the mental  
224.9 health professional providing clinical supervision of the case manager information on the  
224.10 child, the child's family, or services provided to the child or the child's family without  
224.11 informed written consent unless required to do so by statute or under the Minnesota  
224.12 Government Data Practices Act. Informed written consent must comply with section 13.05,  
224.13 subdivision 4, paragraph (d), and specify the purpose and use for which the case manager  
224.14 may disclose the information.

224.15 (b) The consent or authorization must be obtained from the child's parent unless: (1) the  
224.16 parental rights are terminated; or (2) consent is otherwise provided under sections 144.341  
224.17 to 144.347; 253B.04, subdivision 1; 260C.148; 260C.151; and 260C.201, subdivision 1,  
224.18 the terms of appointment of a court-appointed guardian or conservator, or federal regulations  
224.19 governing substance use disorder services.

224.20 Sec. 31. Minnesota Statutes 2024, section 245.4877, is amended to read:

224.21 **245.4877 EDUCATION AND PREVENTION SERVICES.**

224.22 Education and prevention services must be available to all children residing in the county.  
224.23 Education and prevention services must be designed to:

224.24 (1) convey information regarding ~~emotional disturbances~~ mental illnesses, mental health  
224.25 needs, and treatment resources to the general public;

224.26 (2) at least annually, distribute to individuals and agencies identified by the county board  
224.27 and the local children's mental health advisory council information on predictors and  
224.28 symptoms of ~~emotional disturbances~~ mental illnesses, where mental health services are  
224.29 available in the county, and how to access the services;

224.30 (3) increase understanding and acceptance of problems associated with ~~emotional~~  
224.31 ~~disturbances~~ mental illnesses;

224.32 (4) improve people's skills in dealing with high-risk situations known to affect children's  
224.33 mental health and functioning;

- 225.1 (5) prevent development or deepening of ~~emotional disturbances~~ mental illnesses; and
- 225.2 (6) refer each child with ~~emotional disturbance~~ mental illness or the child's family with
- 225.3 additional mental health needs to appropriate mental health services.

225.4 Sec. 32. Minnesota Statutes 2024, section 245.488, subdivision 1, is amended to read:

225.5 Subdivision 1. **Availability of outpatient services.** (a) County boards must provide or

225.6 contract for enough outpatient services within the county to meet the needs of each child

225.7 with ~~emotional disturbance~~ mental illness residing in the county and the child's family.

225.8 Services may be provided directly by the county through county-operated mental health

225.9 clinics meeting the standards of chapter 245I; by contract with privately operated mental

225.10 health clinics meeting the standards of chapter 245I; by contract with hospital mental health

225.11 outpatient programs certified by the Joint Commission on Accreditation of Hospital

225.12 Organizations; or by contract with a mental health professional. A child or a child's parent

225.13 may be required to pay a fee based in accordance with section 245.481. Outpatient services

225.14 include:

- 225.15 (1) conducting diagnostic assessments;
- 225.16 (2) conducting psychological testing;
- 225.17 (3) developing or modifying individual treatment plans;
- 225.18 (4) making referrals and recommending placements as appropriate;
- 225.19 (5) treating the child's mental health needs through therapy; and
- 225.20 (6) prescribing and managing medication and evaluating the effectiveness of prescribed
- 225.21 medication.

225.22 (b) County boards may request a waiver allowing outpatient services to be provided in

225.23 a nearby trade area if it is determined that the child requires necessary and appropriate

225.24 services that are only available outside the county.

225.25 (c) Outpatient services offered by the county board to prevent placement must be at the

225.26 level of treatment appropriate to the child's diagnostic assessment.

225.27 Sec. 33. Minnesota Statutes 2024, section 245.488, subdivision 3, is amended to read:

225.28 Subd. 3. **Mental health crisis services.** County boards must provide or contract for

225.29 mental health crisis services within the county to meet the needs of children with ~~emotional~~

225.30 ~~disturbance~~ mental illness residing in the county who are determined, through an assessment

225.31 by a mental health professional, to be experiencing a mental health crisis or mental health

226.1 emergency. The mental health crisis services provided must be medically necessary, as  
226.2 defined in section 62Q.53, subdivision 2, and necessary for the safety of the child or others  
226.3 regardless of the setting.

226.4 Sec. 34. Minnesota Statutes 2024, section 245.4881, subdivision 1, is amended to read:

226.5 Subdivision 1. **Availability of case management services.** (a) The county board shall  
226.6 provide case management services for each child with ~~severe emotional disturbance~~ serious  
226.7 mental illness who is a resident of the county and the child's family who request or consent  
226.8 to the services. Case management services must be offered to a child with a serious ~~emotional~~  
226.9 ~~disturbance~~ mental illness who is over the age of 18 consistent with section 245.4875,  
226.10 subdivision 8, or the child's legal representative, provided the child's service needs can be  
226.11 met within the children's service system. Before discontinuing case management services  
226.12 under this subdivision for children between the ages of 17 and 21, a transition plan must be  
226.13 developed. The transition plan must be developed with the child and, with the consent of a  
226.14 child age 18 or over, the child's parent, guardian, or legal representative. The transition plan  
226.15 should include plans for health insurance, housing, education, employment, and treatment.  
226.16 Staffing ratios must be sufficient to serve the needs of the clients. The case manager must  
226.17 meet the requirements in section 245.4871, subdivision 4.

226.18 (b) Except as permitted by law and the commissioner under demonstration projects, case  
226.19 management services provided to children with ~~severe emotional disturbance~~ serious mental  
226.20 illness eligible for medical assistance must be billed to the medical assistance program under  
226.21 sections 256B.02, subdivision 8, and 256B.0625.

226.22 (c) Case management services are eligible for reimbursement under the medical assistance  
226.23 program. Costs of mentoring, supervision, and continuing education may be included in the  
226.24 reimbursement rate methodology used for case management services under the medical  
226.25 assistance program.

226.26 Sec. 35. Minnesota Statutes 2024, section 245.4881, subdivision 4, is amended to read:

226.27 Subd. 4. **Individual family community support plan.** (a) For each child, the case  
226.28 manager must develop an individual family community support plan that incorporates the  
226.29 child's individual treatment plan. The individual treatment plan may not be a substitute for  
226.30 the development of an individual family community support plan. The case manager is  
226.31 responsible for developing the individual family community support plan within 30 days  
226.32 of intake based on a diagnostic assessment and for implementing and monitoring the delivery  
226.33 of services according to the individual family community support plan. The case manager

227.1 must review the plan at least every 180 calendar days after it is developed, unless the case  
227.2 manager has received a written request from the child's family or an advocate for the child  
227.3 for a review of the plan every 90 days after it is developed. To the extent appropriate, the  
227.4 child with ~~severe emotional disturbance~~ serious mental illness, the child's family, advocates,  
227.5 service providers, and significant others must be involved in all phases of development and  
227.6 implementation of the individual family community support plan. Notwithstanding the lack  
227.7 of an individual family community support plan, the case manager shall assist the child and  
227.8 child's family in accessing the needed services listed in section 245.4884, subdivision 1.

227.9 (b) The child's individual family community support plan must state:

227.10 (1) the goals and expected outcomes of each service and criteria for evaluating the  
227.11 effectiveness and appropriateness of the service;

227.12 (2) the activities for accomplishing each goal;

227.13 (3) a schedule for each activity; and

227.14 (4) the frequency of face-to-face contacts by the case manager, as appropriate to client  
227.15 need and the implementation of the individual family community support plan.

227.16 Sec. 36. Minnesota Statutes 2024, section 245.4882, subdivision 1, is amended to read:

227.17 Subdivision 1. **Availability of residential treatment services.** County boards must  
227.18 provide or contract for enough residential treatment services to meet the needs of each child  
227.19 with ~~severe emotional disturbance~~ serious mental illness residing in the county and needing  
227.20 this level of care. Length of stay is based on the child's residential treatment need and shall  
227.21 be reviewed every 90 days. Services must be appropriate to the child's age and treatment  
227.22 needs and must be made available as close to the county as possible. Residential treatment  
227.23 must be designed to:

227.24 (1) help the child improve family living and social interaction skills;

227.25 (2) help the child gain the necessary skills to return to the community;

227.26 (3) stabilize crisis admissions; and

227.27 (4) work with families throughout the placement to improve the ability of the families  
227.28 to care for children with ~~severe emotional disturbance~~ serious mental illness in the home.

227.29 Sec. 37. Minnesota Statutes 2024, section 245.4882, subdivision 5, is amended to read:

227.30 Subd. 5. **Specialized residential treatment services.** The commissioner of human  
227.31 services shall continue efforts to further interagency collaboration to develop a comprehensive

228.1 system of services, including family community support and specialized residential treatment  
228.2 services for children. The services shall be designed for children with ~~emotional disturbance~~  
228.3 mental illness who exhibit violent or destructive behavior and for whom local treatment  
228.4 services are not feasible due to the small number of children statewide who need the services  
228.5 and the specialized nature of the services required. The services shall be located in community  
228.6 settings.

228.7 Sec. 38. Minnesota Statutes 2024, section 245.4884, is amended to read:

228.8 **245.4884 FAMILY COMMUNITY SUPPORT SERVICES.**

228.9 Subdivision 1. **Availability of family community support services.** By July 1, 1991,  
228.10 county boards must provide or contract for sufficient family community support services  
228.11 within the county to meet the needs of each child with ~~severe emotional disturbance~~ serious  
228.12 mental illness who resides in the county and the child's family. Children or their parents  
228.13 may be required to pay a fee in accordance with section 245.481.

228.14 Family community support services must be designed to improve the ability of children  
228.15 with ~~severe emotional disturbance~~ serious mental illness to:

- 228.16 (1) manage basic activities of daily living;
- 228.17 (2) function appropriately in home, school, and community settings;
- 228.18 (3) participate in leisure time or community youth activities;
- 228.19 (4) set goals and plans;
- 228.20 (5) reside with the family in the community;
- 228.21 (6) participate in after-school and summer activities;
- 228.22 (7) make a smooth transition among mental health and education services provided to  
228.23 children; and
- 228.24 (8) make a smooth transition into the adult mental health system as appropriate.

228.25 In addition, family community support services must be designed to improve overall  
228.26 family functioning if clinically appropriate to the child's needs, and to reduce the need for  
228.27 and use of placements more intensive, costly, or restrictive both in the number of admissions  
228.28 and lengths of stay than indicated by the child's diagnostic assessment.

228.29 The commissioner of human services shall work with mental health professionals to  
228.30 develop standards for clinical supervision of family community support services. These

229.1 standards shall be incorporated in rule and in guidelines for grants for family community  
229.2 support services.

229.3 Subd. 2. **Day treatment services provided.** (a) Day treatment services must be part of  
229.4 the family community support services available to each child with ~~severe emotional~~  
229.5 ~~disturbance~~ serious mental illness residing in the county. A child or the child's parent may  
229.6 be required to pay a fee according to section 245.481. Day treatment services must be  
229.7 designed to:

229.8 (1) provide a structured environment for treatment;

229.9 (2) provide support for residing in the community;

229.10 (3) prevent placements that are more intensive, costly, or restrictive than necessary to  
229.11 meet the child's need;

229.12 (4) coordinate with or be offered in conjunction with the child's education program;

229.13 (5) provide therapy and family intervention for children that are coordinated with  
229.14 education services provided and funded by schools; and

229.15 (6) operate during all 12 months of the year.

229.16 (b) County boards may request a waiver from including day treatment services if they  
229.17 can document that:

229.18 (1) alternative services exist through the county's family community support services  
229.19 for each child who would otherwise need day treatment services; and

229.20 (2) county demographics and geography make the provision of day treatment services  
229.21 cost ineffective and unfeasible.

229.22 Subd. 3. **Professional home-based family treatment provided.** (a) By January 1, 1991,  
229.23 county boards must provide or contract for sufficient professional home-based family  
229.24 treatment within the county to meet the needs of each child with ~~severe emotional disturbance~~  
229.25 serious mental illness who is at risk of ~~out-of-home placement~~ residential treatment or  
229.26 therapeutic foster care due to the child's ~~emotional disturbance~~ mental illness or who is  
229.27 returning to the home from ~~out-of-home placement~~ residential treatment or therapeutic  
229.28 foster care. The child or the child's parent may be required to pay a fee according to section  
229.29 245.481. The county board shall require that all service providers of professional home-based  
229.30 family treatment set fee schedules approved by the county board that are based on the child's  
229.31 or family's ability to pay. The professional home-based family treatment must be designed  
229.32 to assist each child with ~~severe emotional disturbance~~ serious mental illness who is at risk

230.1 of or who is returning from ~~out-of-home placement~~ residential treatment or therapeutic  
230.2 foster care and the child's family to:

230.3 (1) improve overall family functioning in all areas of life;

230.4 (2) treat the child's symptoms of ~~emotional disturbance~~ mental illness that contribute to  
230.5 a risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care;

230.6 (3) provide a positive change in the emotional, behavioral, and mental well-being of  
230.7 children and their families; and

230.8 (4) reduce risk of ~~out-of-home placement~~ residential treatment or therapeutic foster care  
230.9 for the identified child with ~~severe emotional disturbance~~ serious mental illness and other  
230.10 siblings or successfully reunify and reintegrate into the family a child returning from  
230.11 ~~out-of-home placement~~ residential treatment or therapeutic foster care due to ~~emotional~~  
230.12 ~~disturbance~~ mental illness.

230.13 (b) Professional home-based family treatment must be provided by a team consisting of  
230.14 a mental health professional and others who are skilled in the delivery of mental health  
230.15 services to children and families in conjunction with other human service providers. The  
230.16 professional home-based family treatment team must maintain flexible hours of service  
230.17 availability and must provide or arrange for crisis services for each family, 24 hours a day,  
230.18 seven days a week. Case loads for each professional home-based family treatment team  
230.19 must be small enough to permit the delivery of intensive services and to meet the needs of  
230.20 the family. Professional home-based family treatment providers shall coordinate services  
230.21 and service needs with case managers assigned to children and their families. The treatment  
230.22 team must develop an individual treatment plan that identifies the specific treatment  
230.23 objectives for both the child and the family.

230.24 Subd. 4. **Therapeutic support of foster care.** By January 1, 1992, county boards must  
230.25 provide or contract for foster care with therapeutic support as defined in section 245.4871,  
230.26 subdivision 34. Foster families caring for children with ~~severe emotional disturbance~~ serious  
230.27 mental illness must receive training and supportive services, as necessary, at no cost to the  
230.28 foster families within the limits of available resources.

230.29 Subd. 5. **Benefits assistance.** The county board must offer help to a child with ~~severe~~  
230.30 ~~emotional disturbance~~ serious mental illness and the child's family in applying for federal  
230.31 benefits, including Supplemental Security Income, medical assistance, and Medicare.

231.1 Sec. 39. Minnesota Statutes 2024, section 245.4885, subdivision 1, is amended to read:

231.2 Subdivision 1. **Admission criteria.** (a) Prior to admission or placement, except in the  
231.3 case of an emergency, all children referred for treatment of ~~severe emotional disturbance~~  
231.4 serious mental illness in a treatment foster care setting, residential treatment facility, or  
231.5 informally admitted to a regional treatment center shall undergo an assessment to determine  
231.6 the appropriate level of care if county funds are used to pay for the child's services. An  
231.7 emergency includes when a child is in need of and has been referred for crisis stabilization  
231.8 services under section 245.4882, subdivision 6. A child who has been referred to residential  
231.9 treatment for crisis stabilization services in a residential treatment center is not required to  
231.10 undergo an assessment under this section.

231.11 (b) The county board shall determine the appropriate level of care for a child when  
231.12 county-controlled funds are used to pay for the child's residential treatment under this  
231.13 chapter, including residential treatment provided in a qualified residential treatment program  
231.14 as defined in section 260C.007, subdivision 26d. When a county board does not have  
231.15 responsibility for a child's placement and the child is enrolled in a prepaid health program  
231.16 under section 256B.69, the enrolled child's contracted health plan must determine the  
231.17 appropriate level of care for the child. When Indian Health Services funds or funds of a  
231.18 tribally owned facility funded under the Indian Self-Determination and Education Assistance  
231.19 Act, Public Law 93-638, are used for the child, the Indian Health Services or 638 tribal  
231.20 health facility must determine the appropriate level of care for the child. When more than  
231.21 one entity bears responsibility for a child's coverage, the entities shall coordinate level of  
231.22 care determination activities for the child to the extent possible.

231.23 (c) The child's level of care determination shall determine whether the proposed treatment:

231.24 (1) is necessary;

231.25 (2) is appropriate to the child's individual treatment needs;

231.26 (3) cannot be effectively provided in the child's home; and

231.27 (4) provides a length of stay as short as possible consistent with the individual child's  
231.28 needs.

231.29 (d) When a level of care determination is conducted, the county board or other entity  
231.30 may not determine that a screening of a child, referral, or admission to a residential treatment  
231.31 facility is not appropriate solely because services were not first provided to the child in a  
231.32 less restrictive setting and the child failed to make progress toward or meet treatment goals  
231.33 in the less restrictive setting. The level of care determination must be based on a diagnostic

232.1 assessment of a child that evaluates the child's family, school, and community living  
232.2 situations; and an assessment of the child's need for care out of the home using a validated  
232.3 tool which assesses a child's functional status and assigns an appropriate level of care to the  
232.4 child. The validated tool must be approved by the commissioner of human services and  
232.5 may be the validated tool approved for the child's assessment under section 260C.704 if the  
232.6 juvenile treatment screening team recommended placement of the child in a qualified  
232.7 residential treatment program. If a diagnostic assessment has been completed by a mental  
232.8 health professional within the past 180 days, a new diagnostic assessment need not be  
232.9 completed unless in the opinion of the current treating mental health professional the child's  
232.10 mental health status has changed markedly since the assessment was completed. The child's  
232.11 parent shall be notified if an assessment will not be completed and of the reasons. A copy  
232.12 of the notice shall be placed in the child's file. Recommendations developed as part of the  
232.13 level of care determination process shall include specific community services needed by  
232.14 the child and, if appropriate, the child's family, and shall indicate whether these services  
232.15 are available and accessible to the child and the child's family. The child and the child's  
232.16 family must be invited to any meeting where the level of care determination is discussed  
232.17 and decisions regarding residential treatment are made. The child and the child's family  
232.18 may invite other relatives, friends, or advocates to attend these meetings.

232.19 (e) During the level of care determination process, the child, child's family, or child's  
232.20 legal representative, as appropriate, must be informed of the child's eligibility for case  
232.21 management services and family community support services and that an individual family  
232.22 community support plan is being developed by the case manager, if assigned.

232.23 (f) The level of care determination, placement decision, and recommendations for mental  
232.24 health services must be documented in the child's record and made available to the child's  
232.25 family, as appropriate.

232.26 Sec. 40. Minnesota Statutes 2024, section 245.4889, subdivision 1, is amended to read:

232.27 Subdivision 1. **Establishment and authority.** (a) The commissioner is authorized to  
232.28 make grants from available appropriations to assist:

232.29 (1) counties;

232.30 (2) Indian tribes;

232.31 (3) children's collaboratives under section 142D.15 or 245.493; or

232.32 (4) mental health service providers.

232.33 (b) The following services are eligible for grants under this section:

- 233.1 (1) services to children with ~~emotional disturbances~~ mental illness as defined in section  
233.2 245.4871, subdivision 15, and their families;
- 233.3 (2) transition services under section 245.4875, subdivision 8, for young adults under  
233.4 age 21 and their families;
- 233.5 (3) respite care services for children with ~~emotional disturbances~~ mental illness or ~~severe~~  
233.6 ~~emotional disturbances~~ serious mental illness who are at risk of residential treatment or  
233.7 hospitalization; who are already in ~~out-of-home placement~~ residential treatment, therapeutic  
233.8 foster care, or in family foster settings as defined in chapter 142B and at risk of change in  
233.9 ~~out-of-home placement~~ foster care or placement in a residential facility or other higher level  
233.10 of care; who have utilized crisis services or emergency room services; or who have  
233.11 experienced a loss of in-home staffing support. Allowable activities and expenses for respite  
233.12 care services are defined under subdivision 4. A child is not required to have case  
233.13 management services to receive respite care services. Counties must work to provide access  
233.14 to regularly scheduled respite care;
- 233.15 (4) children's mental health crisis services;
- 233.16 (5) child-, youth-, and family-specific mobile response and stabilization services models;
- 233.17 (6) mental health services for people from cultural and ethnic minorities, including  
233.18 supervision of clinical trainees who are Black, indigenous, or people of color;
- 233.19 (7) children's mental health screening and follow-up diagnostic assessment and treatment;
- 233.20 (8) services to promote and develop the capacity of providers to use evidence-based  
233.21 practices in providing children's mental health services;
- 233.22 (9) school-linked mental health services under section 245.4901;
- 233.23 (10) building evidence-based mental health intervention capacity for children birth to  
233.24 age five;
- 233.25 (11) suicide prevention and counseling services that use text messaging statewide;
- 233.26 (12) mental health first aid training;
- 233.27 (13) training for parents, collaborative partners, and mental health providers on the  
233.28 impact of adverse childhood experiences and trauma and development of an interactive  
233.29 website to share information and strategies to promote resilience and prevent trauma;
- 233.30 (14) transition age services to develop or expand mental health treatment and supports  
233.31 for adolescents and young adults 26 years of age or younger;

- 234.1 (15) early childhood mental health consultation;
- 234.2 (16) evidence-based interventions for youth at risk of developing or experiencing a first  
234.3 episode of psychosis, and a public awareness campaign on the signs and symptoms of  
234.4 psychosis;
- 234.5 (17) psychiatric consultation for primary care practitioners; and
- 234.6 (18) providers to begin operations and meet program requirements when establishing a  
234.7 new children's mental health program. These may be start-up grants.
- 234.8 (c) Services under paragraph (b) must be designed to help each child to function and  
234.9 remain with the child's family in the community and delivered consistent with the child's  
234.10 treatment plan. Transition services to eligible young adults under this paragraph must be  
234.11 designed to foster independent living in the community.
- 234.12 (d) As a condition of receiving grant funds, a grantee shall obtain all available third-party  
234.13 reimbursement sources, if applicable.
- 234.14 (e) The commissioner may establish and design a pilot program to expand the mobile  
234.15 response and stabilization services model for children, youth, and families. The commissioner  
234.16 may use grant funding to consult with a qualified expert entity to assist in the formulation  
234.17 of measurable outcomes and explore and position the state to submit a Medicaid state plan  
234.18 amendment to scale the model statewide.
- 234.19 Sec. 41. Minnesota Statutes 2024, section 245.4907, subdivision 2, is amended to read:
- 234.20 Subd. 2. **Eligible applicants.** An eligible applicant is a licensed entity or provider that  
234.21 employs a mental health certified peer family specialist qualified under section 245I.04,  
234.22 subdivision 12, and that provides services to families who have a child:
- 234.23 (1) with ~~an emotional disturbance~~ a mental illness or ~~severe emotional disturbance~~ serious  
234.24 mental illness under chapter 245;
- 234.25 (2) receiving inpatient hospitalization under section 256B.0625, subdivision 1;
- 234.26 (3) admitted to a residential treatment facility under section 245.4882;
- 234.27 (4) receiving children's intensive behavioral health services under section 256B.0946;
- 234.28 (5) receiving day treatment or children's therapeutic services and supports under section  
234.29 256B.0943; or
- 234.30 (6) receiving crisis response services under section 256B.0624.

235.1 Sec. 42. Minnesota Statutes 2024, section 245.491, subdivision 2, is amended to read:

235.2 Subd. 2. **Purpose.** The legislature finds that children with mental illnesses or emotional  
235.3 or behavioral disturbances or who are at risk of suffering such disturbances often require  
235.4 services from multiple service systems including mental health, social services, education,  
235.5 corrections, juvenile court, health, and employment and economic development. In order  
235.6 to better meet the needs of these children, it is the intent of the legislature to establish an  
235.7 integrated children's mental health service system that:

235.8 (1) allows local service decision makers to draw funding from a single local source so  
235.9 that funds follow clients and eliminates the need to match clients, funds, services, and  
235.10 provider eligibilities;

235.11 (2) creates a local pool of state, local, and private funds to procure a greater medical  
235.12 assistance federal financial participation;

235.13 (3) improves the efficiency of use of existing resources;

235.14 (4) minimizes or eliminates the incentives for cost and risk shifting; and

235.15 (5) increases the incentives for earlier identification and intervention.

235.16 The children's mental health integrated fund established under sections 245.491 to 245.495  
235.17 must be used to develop and support this integrated mental health service system. In  
235.18 developing this integrated service system, it is not the intent of the legislature to limit any  
235.19 rights available to children and their families through existing federal and state laws.

235.20 Sec. 43. Minnesota Statutes 2024, section 245.492, subdivision 3, is amended to read:

235.21 Subd. 3. **Children with emotional or behavioral disturbances.** "Children with  
235.22 emotional or behavioral disturbances" includes children with ~~emotional disturbances~~ mental  
235.23 illnesses as defined in section 245.4871, subdivision 15, and children with emotional or  
235.24 behavioral disorders as defined in Minnesota Rules, part 3525.1329, subpart 1.

235.25 Sec. 44. Minnesota Statutes 2024, section 245.697, subdivision 2a, is amended to read:

235.26 Subd. 2a. **Subcommittee on Children's Mental Health.** The State Advisory Council  
235.27 on Mental Health (the "advisory council") must have a Subcommittee on Children's Mental  
235.28 Health. The subcommittee must make recommendations to the advisory council on policies,  
235.29 laws, regulations, and services relating to children's mental health. Members of the  
235.30 subcommittee must include:

- 236.1 (1) the commissioners or designees of the commissioners of the Departments of Human  
236.2 Services, Health, Education, State Planning, and Corrections;
- 236.3 (2) a designee of the Direct Care and Treatment executive board;
- 236.4 (3) the commissioner of commerce or a designee of the commissioner who is  
236.5 knowledgeable about medical insurance issues;
- 236.6 (4) at least one representative of an advocacy group for children with ~~emotional~~  
236.7 ~~disturbances~~ mental illnesses;
- 236.8 (5) providers of children's mental health services, including at least one provider of  
236.9 services to preadolescent children, one provider of services to adolescents, and one  
236.10 hospital-based provider;
- 236.11 (6) parents of children who have ~~emotional disturbances~~ mental illnesses;
- 236.12 (7) a present or former consumer of adolescent mental health services;
- 236.13 (8) educators currently working with ~~emotionally disturbed~~ children with mental illnesses;
- 236.14 (9) people knowledgeable about the needs of ~~emotionally disturbed~~ children with mental  
236.15 illnesses of minority races and cultures;
- 236.16 (10) people experienced in working with ~~emotionally disturbed~~ children with mental  
236.17 illnesses who have committed status offenses;
- 236.18 (11) members of the advisory council;
- 236.19 (12) one person from the local corrections department and one representative of the  
236.20 Minnesota District Judges Association Juvenile Committee; and
- 236.21 (13) county commissioners and social services agency representatives.
- 236.22 The chair of the advisory council shall appoint subcommittee members described in  
236.23 clauses (4) to (12) through the process established in section 15.0597. The chair shall appoint  
236.24 members to ensure a geographical balance on the subcommittee. Terms, compensation,  
236.25 removal, and filling of vacancies are governed by subdivision 1, except that terms of  
236.26 subcommittee members who are also members of the advisory council are coterminous with  
236.27 their terms on the advisory council. The subcommittee shall meet at the call of the  
236.28 subcommittee chair who is elected by the subcommittee from among its members. The  
236.29 subcommittee expires with the expiration of the advisory council.

237.1 Sec. 45. Minnesota Statutes 2024, section 245.814, subdivision 3, is amended to read:

237.2 Subd. 3. **Compensation provisions.** (a) If the commissioner of human services is unable  
237.3 to obtain insurance through ordinary methods for coverage of foster home providers, the  
237.4 appropriation shall be returned to the general fund and the state shall pay claims subject to  
237.5 the following limitations.

237.6 ~~(a)~~ (b) Compensation shall be provided only for injuries, damage, or actions set forth in  
237.7 subdivision 1.

237.8 ~~(b)~~ (c) Compensation shall be subject to the conditions and exclusions set forth in  
237.9 subdivision 2.

237.10 ~~(c)~~ (d) The state shall provide compensation for bodily injury, property damage, or  
237.11 personal injury resulting from the foster home providers activities as a foster home provider  
237.12 while the foster child or adult is in the care, custody, and control of the foster home provider  
237.13 in an amount not to exceed \$250,000 for each occurrence.

237.14 ~~(d)~~ (e) The state shall provide compensation for damage or destruction of property caused  
237.15 or sustained by a foster child or adult in an amount not to exceed \$250 for each occurrence.

237.16 ~~(e)~~ (f) The compensation in paragraphs ~~(c)~~ and (d) and (e) is the total obligation for all  
237.17 damages because of each occurrence regardless of the number of claims made in connection  
237.18 with the same occurrence, but compensation applies separately to each foster home. The  
237.19 state shall have no other responsibility to provide compensation for any injury or loss caused  
237.20 or sustained by any foster home provider or foster child or foster adult.

237.21 (g) This coverage is extended as a benefit to foster home providers to encourage care  
237.22 of persons who need ~~out-of-home~~ the providers' care. Nothing in this section shall be  
237.23 construed to mean that foster home providers are agents or employees of the state nor does  
237.24 the state accept any responsibility for the selection, monitoring, supervision, or control of  
237.25 foster home providers which is exclusively the responsibility of the counties which shall  
237.26 regulate foster home providers in the manner set forth in the rules of the commissioner of  
237.27 human services.

238.1 Sec. 46. Minnesota Statutes 2024, section 245.826, is amended to read:

238.2 **245.826 USE OF RESTRICTIVE TECHNIQUES AND PROCEDURES IN**  
238.3 **FACILITIES SERVING ~~EMOTIONALLY DISTURBED~~ CHILDREN WITH**  
238.4 **MENTAL ILLNESSES.**

238.5 When amending rules governing facilities serving ~~emotionally disturbed~~ children with  
238.6 mental illnesses that are licensed under section 245A.09 and Minnesota Rules, parts  
238.7 2960.0510 to 2960.0530 and 2960.0580 to 2960.0700, the commissioner of human services  
238.8 shall include provisions governing the use of restrictive techniques and procedures. No  
238.9 provision of these rules may encourage or require the use of restrictive techniques and  
238.10 procedures. The rules must prohibit: (1) the application of certain restrictive techniques or  
238.11 procedures in facilities, except as authorized in the child's case plan and monitored by the  
238.12 county caseworker responsible for the child; (2) the use of restrictive techniques or procedures  
238.13 that restrict the clients' normal access to nutritious diet, drinking water, adequate ventilation,  
238.14 necessary medical care, ordinary hygiene facilities, normal sleeping conditions, and necessary  
238.15 clothing; and (3) the use of corporal punishment. The rule may specify other restrictive  
238.16 techniques and procedures and the specific conditions under which permitted techniques  
238.17 and procedures are to be carried out.

238.18 Sec. 47. Minnesota Statutes 2024, section 245.91, subdivision 2, is amended to read:

238.19 Subd. 2. **Agency.** "Agency" means the divisions, officials, or employees of the state  
238.20 Departments of Human Services, Direct Care and Treatment, Health, and Education, and  
238.21 of local school districts and designated county social service agencies as defined in section  
238.22 256G.02, subdivision 7, that are engaged in monitoring, providing, or regulating services  
238.23 or treatment for mental illness, developmental disability, or substance use disorder, ~~or~~  
238.24 ~~emotional disturbance.~~

238.25 Sec. 48. Minnesota Statutes 2024, section 245.91, subdivision 4, is amended to read:

238.26 Subd. 4. **Facility or program.** "Facility" or "program" means a nonresidential or  
238.27 residential program as defined in section 245A.02, subdivisions 10 and 14, and any agency,  
238.28 facility, or program that provides services or treatment for mental illness, developmental  
238.29 disability, or substance use disorder, ~~or emotional disturbance~~ that is required to be licensed,  
238.30 certified, or registered by the commissioner of human services, health, or education; a sober  
238.31 home as defined in section 254B.01, subdivision 11; peer recovery support services provided  
238.32 by a recovery community organization as defined in section 254B.01, subdivision 8; and

239.1 an acute care inpatient facility that provides services or treatment for mental illness,  
239.2 developmental disability, or substance use disorder, ~~or emotional disturbance.~~

239.3 Sec. 49. Minnesota Statutes 2024, section 245.92, is amended to read:

239.4 **245.92 OFFICE OF OMBUDSMAN; CREATION; QUALIFICATIONS;**  
239.5 **FUNCTION.**

239.6 The ombudsman for persons receiving services or treatment for mental illness,  
239.7 developmental disability, or substance use disorder, ~~or emotional disturbance~~ shall promote  
239.8 the highest attainable standards of treatment, competence, efficiency, and justice. The  
239.9 ombudsman may gather information and data about decisions, acts, and other matters of an  
239.10 agency, facility, or program, and shall monitor the treatment of individuals participating in  
239.11 a University of Minnesota Department of Psychiatry clinical drug trial. The ombudsman is  
239.12 appointed by the governor, serves in the unclassified service, and may be removed only for  
239.13 just cause. The ombudsman must be selected without regard to political affiliation and must  
239.14 be a person who has knowledge and experience concerning the treatment, needs, and rights  
239.15 of clients, and who is highly competent and qualified. No person may serve as ombudsman  
239.16 while holding another public office.

239.17 Sec. 50. Minnesota Statutes 2024, section 245.94, subdivision 1, is amended to read:

239.18 Subdivision 1. **Powers.** (a) The ombudsman may prescribe the methods by which  
239.19 complaints to the office are to be made, reviewed, and acted upon. The ombudsman may  
239.20 not levy a complaint fee.

239.21 (b) The ombudsman is a health oversight agency as defined in Code of Federal  
239.22 Regulations, title 45, section 164.501. The ombudsman may access patient records according  
239.23 to Code of Federal Regulations, title 42, section 2.53. For purposes of this paragraph,  
239.24 "records" has the meaning given in Code of Federal Regulations, title 42, section  
239.25 2.53(a)(1)(i).

239.26 (c) The ombudsman may mediate or advocate on behalf of a client.

239.27 (d) The ombudsman may investigate the quality of services provided to clients and  
239.28 determine the extent to which quality assurance mechanisms within state and county  
239.29 government work to promote the health, safety, and welfare of clients.

239.30 (e) At the request of a client, or upon receiving a complaint or other information affording  
239.31 reasonable grounds to believe that the rights of one or more clients who may not be capable  
239.32 of requesting assistance have been adversely affected, the ombudsman may gather

240.1 information and data about and analyze, on behalf of the client, the actions of an agency,  
240.2 facility, or program.

240.3 (f) The ombudsman may gather, on behalf of one or more clients, records of an agency,  
240.4 facility, or program, or records related to clinical drug trials from the University of Minnesota  
240.5 Department of Psychiatry, if the records relate to a matter that is within the scope of the  
240.6 ombudsman's authority. If the records are private and the client is capable of providing  
240.7 consent, the ombudsman shall first obtain the client's consent. The ombudsman is not  
240.8 required to obtain consent for access to private data on clients with developmental disabilities  
240.9 and individuals served by the Minnesota Sex Offender Program. The ombudsman may also  
240.10 take photographic or videographic evidence while reviewing the actions of an agency,  
240.11 facility, or program, with the consent of the client. The ombudsman is not required to obtain  
240.12 consent for access to private data on decedents who were receiving services for mental  
240.13 illness, developmental disability, or substance use disorder, ~~or emotional disturbance~~. All  
240.14 data collected, created, received, or maintained by the ombudsman are governed by chapter  
240.15 13 and other applicable law.

240.16 (g) Notwithstanding any law to the contrary, the ombudsman may subpoena a person  
240.17 to appear, give testimony, or produce documents or other evidence that the ombudsman  
240.18 considers relevant to a matter under inquiry. The ombudsman may petition the appropriate  
240.19 court in Ramsey County to enforce the subpoena. A witness who is at a hearing or is part  
240.20 of an investigation possesses the same privileges that a witness possesses in the courts or  
240.21 under the law of this state. Data obtained from a person under this paragraph are private  
240.22 data as defined in section 13.02, subdivision 12.

240.23 (h) The ombudsman may, at reasonable times in the course of conducting a review, enter  
240.24 and view premises within the control of an agency, facility, or program.

240.25 (i) The ombudsman may attend Direct Care and Treatment Review Board and Special  
240.26 Review Board proceedings; proceedings regarding the transfer of clients, as defined in  
240.27 section 246.50, subdivision 4, between institutions operated by the Direct Care and Treatment  
240.28 executive board; and, subject to the consent of the affected client, other proceedings affecting  
240.29 the rights of clients. The ombudsman is not required to obtain consent to attend meetings  
240.30 or proceedings and have access to private data on clients with developmental disabilities  
240.31 and individuals served by the Minnesota Sex Offender Program.

240.32 (j) The ombudsman shall gather data of agencies, facilities, or programs classified as  
240.33 private or confidential as defined in section 13.02, subdivisions 3 and 12, regarding services

241.1 provided to clients with developmental disabilities and individuals served by the Minnesota  
241.2 Sex Offender Program.

241.3 (k) To avoid duplication and preserve evidence, the ombudsman shall inform relevant  
241.4 licensing or regulatory officials before undertaking a review of an action of the facility or  
241.5 program.

241.6 (l) The Office of Ombudsman shall provide the services of the Civil Commitment  
241.7 Training and Resource Center.

241.8 (m) The ombudsman shall monitor the treatment of individuals participating in a  
241.9 University of Minnesota Department of Psychiatry clinical drug trial and ensure that all  
241.10 protections for human subjects required by federal law and the Institutional Review Board  
241.11 are provided.

241.12 (n) Sections 245.91 to 245.97 are in addition to other provisions of law under which any  
241.13 other remedy or right is provided.

241.14 Sec. 51. Minnesota Statutes 2024, section 245A.03, subdivision 2, is amended to read:

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

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

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

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

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

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

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

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

- 242.1 (8) board and lodge facilities licensed by the commissioner of health that do not provide  
242.2 children's residential services under Minnesota Rules, chapter 2960, mental health or  
242.3 substance use disorder treatment;
- 242.4 (9) programs licensed by the commissioner of corrections;
- 242.5 (10) recreation programs for children or adults that are operated or approved by a park  
242.6 and recreation board whose primary purpose is to provide social and recreational activities;
- 242.7 (11) noncertified boarding care homes unless they provide services for five or more  
242.8 persons whose primary diagnosis is mental illness or a developmental disability;
- 242.9 (12) programs for children such as scouting, boys clubs, girls clubs, and sports and art  
242.10 programs, and nonresidential programs for children provided for a cumulative total of less  
242.11 than 30 days in any 12-month period;
- 242.12 (13) residential programs for persons with mental illness, that are located in hospitals;
- 242.13 (14) camps licensed by the commissioner of health under Minnesota Rules, chapter  
242.14 4630;
- 242.15 (15) mental health outpatient services for adults with mental illness or children with  
242.16 ~~emotional disturbance~~ mental illness;
- 242.17 (16) residential programs serving school-age children whose sole purpose is cultural or  
242.18 educational exchange, until the commissioner adopts appropriate rules;
- 242.19 (17) community support services programs as defined in section 245.462, subdivision  
242.20 6, and family community support services as defined in section 245.4871, subdivision 17;
- 242.21 (18) assisted living facilities licensed by the commissioner of health under chapter 144G;
- 242.22 (19) substance use disorder treatment activities of licensed professionals in private  
242.23 practice as defined in section 245G.01, subdivision 17;
- 242.24 (20) consumer-directed community support service funded under the Medicaid waiver  
242.25 for persons with developmental disabilities when the individual who provided the service  
242.26 is:
- 242.27 (i) the same individual who is the direct payee of these specific waiver funds or paid by  
242.28 a fiscal agent, fiscal intermediary, or employer of record; and
- 242.29 (ii) not otherwise under the control of a residential or nonresidential program that is  
242.30 required to be licensed under this chapter when providing the service;

243.1 (21) a county that is an eligible vendor under section 254B.05 to provide care coordination  
243.2 and comprehensive assessment services;

243.3 (22) a recovery community organization that is an eligible vendor under section 254B.05  
243.4 to provide peer recovery support services; or

243.5 (23) programs licensed by the commissioner of children, youth, and families in chapter  
243.6 142B.

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

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

243.15 Sec. 52. Minnesota Statutes 2024, section 245A.26, subdivision 1, is amended to read:

243.16 Subdivision 1. **Definitions.** (a) For the purposes of this section, the terms defined in this  
243.17 subdivision have the meanings given.

243.18 (b) "Clinical trainee" means a staff person who is qualified under section 245I.04,  
243.19 subdivision 6.

243.20 (c) "License holder" means an individual, organization, or government entity that was  
243.21 issued a license by the commissioner of human services under this chapter for residential  
243.22 mental health treatment for children with ~~emotional disturbance~~ mental illness according  
243.23 to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to 2960.0700, or shelter  
243.24 care services according to Minnesota Rules, parts 2960.0010 to 2960.0120 and 2960.0510  
243.25 to 2960.0530.

243.26 (d) "Mental health professional" means an individual who is qualified under section  
243.27 245I.04, subdivision 2.

243.28 Sec. 53. Minnesota Statutes 2024, section 245A.26, subdivision 2, is amended to read:

243.29 Subd. 2. **Scope and applicability.** (a) This section establishes additional licensing  
243.30 requirements for a children's residential facility to provide children's residential crisis

244.1 stabilization services to a client who is experiencing a mental health crisis and is in need of  
244.2 residential treatment services.

244.3 (b) A children's residential facility may provide residential crisis stabilization services  
244.4 only if the facility is licensed to provide:

244.5 (1) residential mental health treatment for children with ~~emotional disturbance~~ mental  
244.6 illness according to Minnesota Rules, parts 2960.0010 to 2960.0220 and 2960.0580 to  
244.7 2960.0700; or

244.8 (2) shelter care services according to Minnesota Rules, parts 2960.0010 to 2960.0120  
244.9 and 2960.0510 to 2960.0530.

244.10 (c) If a client receives residential crisis stabilization services for 35 days or fewer in a  
244.11 facility licensed according to paragraph (b), clause (1), the facility is not required to complete  
244.12 a diagnostic assessment or treatment plan under Minnesota Rules, part 2960.0180, subpart  
244.13 2, and part 2960.0600.

244.14 (d) If a client receives residential crisis stabilization services for 35 days or fewer in a  
244.15 facility licensed according to paragraph (b), clause (2), the facility is not required to develop  
244.16 a plan for meeting the client's immediate needs under Minnesota Rules, part 2960.0520,  
244.17 subpart 3.

244.18 Sec. 54. Minnesota Statutes 2024, section 246C.12, subdivision 4, is amended to read:

244.19 Subd. 4. **Staff safety training.** The executive board shall require all staff in mental  
244.20 health and support units at regional treatment centers who have contact with ~~persons~~ children  
244.21 or adults with mental illness ~~or severe emotional disturbance~~ to be appropriately trained in  
244.22 violence reduction and violence prevention and shall establish criteria for such training.  
244.23 Training programs shall be developed with input from consumer advocacy organizations  
244.24 and shall employ violence prevention techniques as preferable to physical interaction.

244.25 Sec. 55. Minnesota Statutes 2024, section 252.27, subdivision 1, is amended to read:

244.26 Subdivision 1. **County of financial responsibility.** Whenever any child who has a  
244.27 developmental disability, or a physical disability or ~~emotional disturbance~~ mental illness is  
244.28 in 24-hour care outside the home including respite care, in a facility licensed by the  
244.29 commissioner of human services, the cost of services shall be paid by the county of financial  
244.30 responsibility determined pursuant to chapter 256G. If the child's parents or guardians do  
244.31 not reside in this state, the cost shall be paid by the responsible governmental agency in the

245.1 state from which the child came, by the parents or guardians of the child if they are financially  
245.2 able, or, if no other payment source is available, by the commissioner of human services.

245.3 Sec. 56. Minnesota Statutes 2024, section 256B.02, subdivision 11, is amended to read:

245.4 Subd. 11. **Related condition.** "Related condition" means a condition:

245.5 (1) that is found to be closely related to a developmental disability, including but not  
245.6 limited to cerebral palsy, epilepsy, autism, fetal alcohol spectrum disorder, and Prader-Willi  
245.7 syndrome; and

245.8 (2) that meets all of the following criteria:

245.9 (i) is severe and chronic;

245.10 (ii) results in impairment of general intellectual functioning or adaptive behavior similar  
245.11 to that of persons with developmental disabilities;

245.12 (iii) requires treatment or services similar to those required for persons with  
245.13 developmental disabilities;

245.14 (iv) is manifested before the person reaches 22 years of age;

245.15 (v) is likely to continue indefinitely;

245.16 (vi) results in substantial functional limitations in three or more of the following areas  
245.17 of major life activity:

245.18 (A) self-care;

245.19 (B) understanding and use of language;

245.20 (C) learning;

245.21 (D) mobility;

245.22 (E) self-direction; or

245.23 (F) capacity for independent living; and

245.24 (vii) is not attributable to mental illness as defined in section 245.462, subdivision 20,  
245.25 ~~or an emotional disturbance as defined in section 245.4871, subdivision 15.~~ For purposes  
245.26 of this item, notwithstanding section 245.462, subdivision 20, or 245.4871, subdivision 15,  
245.27 "mental illness" does not include autism or other pervasive developmental disorders.

246.1 Sec. 57. Minnesota Statutes 2024, section 256B.055, subdivision 12, is amended to read:

246.2 Subd. 12. **Children with disabilities.** (a) A person is eligible for medical assistance if  
246.3 the person is under age 19 and qualifies as a disabled individual under United States Code,  
246.4 title 42, section 1382c(a), and would be eligible for medical assistance under the state plan  
246.5 if residing in a medical institution, and the child requires a level of care provided in a hospital,  
246.6 nursing facility, or intermediate care facility for persons with developmental disabilities,  
246.7 for whom home care is appropriate, provided that the cost to medical assistance under this  
246.8 section is not more than the amount that medical assistance would pay for if the child resides  
246.9 in an institution. After the child is determined to be eligible under this section, the  
246.10 commissioner shall review the child's disability under United States Code, title 42, section  
246.11 1382c(a) and level of care defined under this section no more often than annually and may  
246.12 elect, based on the recommendation of health care professionals under contract with the  
246.13 state medical review team, to extend the review of disability and level of care up to a  
246.14 maximum of four years. The commissioner's decision on the frequency of continuing review  
246.15 of disability and level of care is not subject to administrative appeal under section 256.045.  
246.16 The county agency shall send a notice of disability review to the enrollee six months prior  
246.17 to the date the recertification of disability is due. Nothing in this subdivision shall be  
246.18 construed as affecting other redeterminations of medical assistance eligibility under this  
246.19 chapter and annual cost-effective reviews under this section.

246.20 (b) For purposes of this subdivision, "hospital" means an institution as defined in section  
246.21 144.696, subdivision 3, 144.55, subdivision 3, or Minnesota Rules, part 4640.3600, and  
246.22 licensed pursuant to sections 144.50 to 144.58. For purposes of this subdivision, a child  
246.23 requires a level of care provided in a hospital if the child is determined by the commissioner  
246.24 to need an extensive array of health services, including mental health services, for an  
246.25 undetermined period of time, whose health condition requires frequent monitoring and  
246.26 treatment by a health care professional or by a person supervised by a health care  
246.27 professional, who would reside in a hospital or require frequent hospitalization if these  
246.28 services were not provided, and the daily care needs are more complex than a nursing facility  
246.29 level of care.

246.30 A child with serious ~~emotional disturbance~~ mental illness requires a level of care provided  
246.31 in a hospital if the commissioner determines that the individual requires 24-hour supervision  
246.32 because the person exhibits recurrent or frequent suicidal or homicidal ideation or behavior,  
246.33 recurrent or frequent psychosomatic disorders or somatopsychic disorders that may become  
246.34 life threatening, recurrent or frequent severe socially unacceptable behavior associated with  
246.35 psychiatric disorder, ongoing and chronic psychosis or severe, ongoing and chronic

247.1 developmental problems requiring continuous skilled observation, or severe disabling  
247.2 symptoms for which office-centered outpatient treatment is not adequate, and which overall  
247.3 severely impact the individual's ability to function.

247.4 (c) For purposes of this subdivision, "nursing facility" means a facility which provides  
247.5 nursing care as defined in section 144A.01, subdivision 5, licensed pursuant to sections  
247.6 144A.02 to 144A.10, which is appropriate if a person is in active restorative treatment; is  
247.7 in need of special treatments provided or supervised by a licensed nurse; or has unpredictable  
247.8 episodes of active disease processes requiring immediate judgment by a licensed nurse. For  
247.9 purposes of this subdivision, a child requires the level of care provided in a nursing facility  
247.10 if the child is determined by the commissioner to meet the requirements of the preadmission  
247.11 screening assessment document under section 256B.0911, adjusted to address age-appropriate  
247.12 standards for children age 18 and under.

247.13 (d) For purposes of this subdivision, "intermediate care facility for persons with  
247.14 developmental disabilities" or "ICF/DD" means a program licensed to provide services to  
247.15 persons with developmental disabilities under section 252.28, and chapter 245A, and a  
247.16 physical plant licensed as a supervised living facility under chapter 144, which together are  
247.17 certified by the Minnesota Department of Health as meeting the standards in Code of Federal  
247.18 Regulations, title 42, part 483, for an intermediate care facility which provides services for  
247.19 persons with developmental disabilities who require 24-hour supervision and active treatment  
247.20 for medical, behavioral, or habilitation needs. For purposes of this subdivision, a child  
247.21 requires a level of care provided in an ICF/DD if the commissioner finds that the child has  
247.22 a developmental disability in accordance with section 256B.092, is in need of a 24-hour  
247.23 plan of care and active treatment similar to persons with developmental disabilities, and  
247.24 there is a reasonable indication that the child will need ICF/DD services.

247.25 (e) For purposes of this subdivision, a person requires the level of care provided in a  
247.26 nursing facility if the person requires 24-hour monitoring or supervision and a plan of mental  
247.27 health treatment because of specific symptoms or functional impairments associated with  
247.28 a serious mental illness or disorder diagnosis, which meet severity criteria for mental health  
247.29 established by the commissioner and published in March 1997 as the Minnesota Mental  
247.30 Health Level of Care for Children and Adolescents with Severe Emotional Disorders.

247.31 (f) The determination of the level of care needed by the child shall be made by the  
247.32 commissioner based on information supplied to the commissioner by (1) the parent or  
247.33 guardian, (2) the child's physician or physicians, advanced practice registered nurse or  
247.34 advanced practice registered nurses, or physician assistant or physician assistants, and (3)

248.1 other professionals as requested by the commissioner. The commissioner shall establish a  
248.2 screening team to conduct the level of care determinations according to this subdivision.

248.3 (g) If a child meets the conditions in paragraph (b), (c), (d), or (e), the commissioner  
248.4 must assess the case to determine whether:

248.5 (1) the child qualifies as a disabled individual under United States Code, title 42, section  
248.6 1382c(a), and would be eligible for medical assistance if residing in a medical institution;  
248.7 and

248.8 (2) the cost of medical assistance services for the child, if eligible under this subdivision,  
248.9 would not be more than the cost to medical assistance if the child resides in a medical  
248.10 institution to be determined as follows:

248.11 (i) for a child who requires a level of care provided in an ICF/DD, the cost of care for  
248.12 the child in an institution shall be determined using the average payment rate established  
248.13 for the regional treatment centers that are certified as ICF's/DD;

248.14 (ii) for a child who requires a level of care provided in an inpatient hospital setting  
248.15 according to paragraph (b), cost-effectiveness shall be determined according to Minnesota  
248.16 Rules, part 9505.3520, items F and G; and

248.17 (iii) for a child who requires a level of care provided in a nursing facility according to  
248.18 paragraph (c) or (e), cost-effectiveness shall be determined according to Minnesota Rules,  
248.19 part 9505.3040, except that the nursing facility average rate shall be adjusted to reflect rates  
248.20 which would be paid for children under age 16. The commissioner may authorize an amount  
248.21 up to the amount medical assistance would pay for a child referred to the commissioner by  
248.22 the preadmission screening team under section 256B.0911.

248.23 Sec. 58. Minnesota Statutes 2024, section 256B.0616, subdivision 1, is amended to read:

248.24 Subdivision 1. **Scope.** Medical assistance covers mental health certified family peer  
248.25 specialists services, as established in subdivision 2, subject to federal approval, if provided  
248.26 to recipients who have ~~an emotional disturbance~~ a mental illness or ~~severe emotional~~  
248.27 ~~disturbance~~ serious mental illness under chapter 245, and are provided by a mental health  
248.28 certified family peer specialist who has completed the training under subdivision 5 and is  
248.29 qualified according to section 245I.04, subdivision 12. A family peer specialist cannot  
248.30 provide services to the peer specialist's family.

249.1 Sec. 59. Minnesota Statutes 2024, section 256B.0757, subdivision 2, is amended to read:

249.2 Subd. 2. **Eligible individual.** (a) The commissioner may elect to develop health home  
249.3 models in accordance with United States Code, title 42, section 1396w-4.

249.4 (b) An individual is eligible for health home services under this section if the individual  
249.5 is eligible for medical assistance under this chapter and has a condition that meets the  
249.6 definition of mental illness as described in section 245.462, subdivision 20, paragraph (a),  
249.7 or ~~emotional disturbance as defined in section 245.4871, subdivision 15, clause (2).~~ The  
249.8 commissioner shall establish criteria for determining continued eligibility.

249.9 Sec. 60. Minnesota Statutes 2024, section 256B.0943, subdivision 1, is amended to read:

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

249.12 (b) "Children's therapeutic services and supports" means the flexible package of mental  
249.13 health services for children who require varying therapeutic and rehabilitative levels of  
249.14 intervention to treat a diagnosed ~~emotional disturbance, as defined in section 245.4871,~~  
249.15 ~~subdivision 15, or a diagnosed~~ mental illness, as defined in section 245.462, subdivision  
249.16 20, or 245.4871, subdivision 15. The services are time-limited interventions that are delivered  
249.17 using various treatment modalities and combinations of services designed to reach treatment  
249.18 outcomes identified in the individual treatment plan.

249.19 (c) "Clinical trainee" means a staff person who is qualified according to section 245I.04,  
249.20 subdivision 6.

249.21 (d) "Crisis planning" has the meaning given in section 245.4871, subdivision 9a.

249.22 (e) "Culturally competent provider" means a provider who understands and can utilize  
249.23 to a client's benefit the client's culture when providing services to the client. A provider  
249.24 may be culturally competent because the provider is of the same cultural or ethnic group  
249.25 as the client or the provider has developed the knowledge and skills through training and  
249.26 experience to provide services to culturally diverse clients.

249.27 (f) "Day treatment program" for children means a site-based structured mental health  
249.28 program consisting of psychotherapy for three or more individuals and individual or group  
249.29 skills training provided by a team, under the treatment supervision of a mental health  
249.30 professional.

249.31 (g) "Direct service time" means the time that a mental health professional, clinical trainee,  
249.32 mental health practitioner, or mental health behavioral aide spends face-to-face with a client

250.1 and the client's family or providing covered services through telehealth as defined under  
250.2 section 256B.0625, subdivision 3b. Direct service time includes time in which the provider  
250.3 obtains a client's history, develops a client's treatment plan, records individual treatment  
250.4 outcomes, or provides service components of children's therapeutic services and supports.  
250.5 Direct service time does not include time doing work before and after providing direct  
250.6 services, including scheduling or maintaining clinical records.

250.7 (h) "Direction of mental health behavioral aide" means the activities of a mental health  
250.8 professional, clinical trainee, or mental health practitioner in guiding the mental health  
250.9 behavioral aide in providing services to a client. The direction of a mental health behavioral  
250.10 aide must be based on the client's individual treatment plan and meet the requirements in  
250.11 subdivision 6, paragraph (b), clause (7).

250.12 ~~(i) "Emotional disturbance" has the meaning given in section 245.4871, subdivision 15.~~

250.13 ~~(j)~~ (i) "Individual treatment plan" means the plan described in section 245I.10,  
250.14 subdivisions 7 and 8.

250.15 ~~(k)~~ (j) "Mental health behavioral aide services" means medically necessary one-on-one  
250.16 activities performed by a mental health behavioral aide qualified according to section  
250.17 245I.04, subdivision 16, to assist a child retain or generalize psychosocial skills as previously  
250.18 trained by a mental health professional, clinical trainee, or mental health practitioner and  
250.19 as described in the child's individual treatment plan and individual behavior plan. Activities  
250.20 involve working directly with the child or child's family as provided in subdivision 9,  
250.21 paragraph (b), clause (4).

250.22 ~~(l)~~ (k) "Mental health certified family peer specialist" means a staff person who is  
250.23 qualified according to section 245I.04, subdivision 12.

250.24 ~~(m)~~ (l) "Mental health practitioner" means a staff person who is qualified according to  
250.25 section 245I.04, subdivision 4.

250.26 ~~(n)~~ (m) "Mental health professional" means a staff person who is qualified according to  
250.27 section 245I.04, subdivision 2.

250.28 ~~(o)~~ (n) "Mental health service plan development" includes:

250.29 (1) development and revision of a child's individual treatment plan; and

250.30 (2) administering and reporting standardized outcome measurements approved by the  
250.31 commissioner, as periodically needed to evaluate the effectiveness of treatment.

251.1 ~~(p)~~ (o) "Mental illness," ~~for persons at least age 18 but under age 21,~~ has the meaning  
251.2 given in section 245.462, subdivision 20, paragraph (a), for persons at least age 18 but under  
251.3 age 21, and has the meaning given in section 245.4871, subdivision 15, for children under  
251.4 18 years of age.

251.5 ~~(q)~~ (p) "Psychotherapy" means the treatment described in section 256B.0671, subdivision  
251.6 11.

251.7 ~~(r)~~ (q) "Rehabilitative services" or "psychiatric rehabilitation services" means  
251.8 interventions to: (1) restore a child or adolescent to an age-appropriate developmental  
251.9 trajectory that had been disrupted by a psychiatric illness; or (2) enable the child to  
251.10 self-monitor, compensate for, cope with, counteract, or replace psychosocial skills deficits  
251.11 or maladaptive skills acquired over the course of a psychiatric illness. Psychiatric  
251.12 rehabilitation services for children combine coordinated psychotherapy to address internal  
251.13 psychological, emotional, and intellectual processing deficits, and skills training to restore  
251.14 personal and social functioning. Psychiatric rehabilitation services establish a progressive  
251.15 series of goals with each achievement building upon a prior achievement.

251.16 ~~(s)~~ (r) "Skills training" means individual, family, or group training, delivered by or under  
251.17 the supervision of a mental health professional, designed to facilitate the acquisition of  
251.18 psychosocial skills that are medically necessary to rehabilitate the child to an age-appropriate  
251.19 developmental trajectory heretofore disrupted by a psychiatric illness or to enable the child  
251.20 to self-monitor, compensate for, cope with, counteract, or replace skills deficits or  
251.21 maladaptive skills acquired over the course of a psychiatric illness. Skills training is subject  
251.22 to the service delivery requirements under subdivision 9, paragraph (b), clause (2).

251.23 ~~(t)~~ (s) "Standard diagnostic assessment" means the assessment described in section  
251.24 245I.10, subdivision 6.

251.25 ~~(u)~~ (t) "Treatment supervision" means the supervision described in section 245I.06.

251.26 Sec. 61. Minnesota Statutes 2024, section 256B.0943, subdivision 3, is amended to read:

251.27 Subd. 3. **Determination of client eligibility.** (a) A client's eligibility to receive children's  
251.28 therapeutic services and supports under this section shall be determined based on a standard  
251.29 diagnostic assessment by a mental health professional or a clinical trainee that is performed  
251.30 within one year before the initial start of service and updated as required under section  
251.31 245I.10, subdivision 2. The standard diagnostic assessment must:

252.1 (1) determine whether a child under age 18 has a diagnosis of ~~emotional disturbance~~  
252.2 mental illness or, if the person is between the ages of 18 and 21, whether the person has a  
252.3 mental illness;

252.4 (2) document children's therapeutic services and supports as medically necessary to  
252.5 address an identified disability, functional impairment, and the individual client's needs and  
252.6 goals; and

252.7 (3) be used in the development of the individual treatment plan.

252.8 (b) Notwithstanding paragraph (a), a client may be determined to be eligible for up to  
252.9 five days of day treatment under this section based on a hospital's medical history and  
252.10 presentation examination of the client.

252.11 (c) Children's therapeutic services and supports include development and rehabilitative  
252.12 services that support a child's developmental treatment needs.

252.13 Sec. 62. Minnesota Statutes 2024, section 256B.0943, subdivision 9, is amended to read:

252.14 Subd. 9. **Service delivery criteria.** (a) In delivering services under this section, a certified  
252.15 provider entity must ensure that:

252.16 (1) the provider's caseload size should reasonably enable the provider to play an active  
252.17 role in service planning, monitoring, and delivering services to meet the client's and client's  
252.18 family's needs, as specified in each client's individual treatment plan;

252.19 (2) site-based programs, including day treatment programs, provide staffing and facilities  
252.20 to ensure the client's health, safety, and protection of rights, and that the programs are able  
252.21 to implement each client's individual treatment plan; and

252.22 (3) a day treatment program is provided to a group of clients by a team under the treatment  
252.23 supervision of a mental health professional. The day treatment program must be provided  
252.24 in and by: (i) an outpatient hospital accredited by the Joint Commission on Accreditation  
252.25 of Health Organizations and licensed under sections 144.50 to 144.55; (ii) a community  
252.26 mental health center under section 245.62; or (iii) an entity that is certified under subdivision  
252.27 4 to operate a program that meets the requirements of section 245.4884, subdivision 2, and  
252.28 Minnesota Rules, parts 9505.0170 to 9505.0475. The day treatment program must stabilize  
252.29 the client's mental health status while developing and improving the client's independent  
252.30 living and socialization skills. The goal of the day treatment program must be to reduce or  
252.31 relieve the effects of mental illness and provide training to enable the client to live in the  
252.32 community. The remainder of the structured treatment program may include patient and/or  
252.33 family or group psychotherapy, and individual or group skills training, if included in the

253.1 client's individual treatment plan. Day treatment programs are not part of inpatient or  
253.2 residential treatment services. When a day treatment group that meets the minimum group  
253.3 size requirement temporarily falls below the minimum group size because of a member's  
253.4 temporary absence, medical assistance covers a group session conducted for the group  
253.5 members in attendance. A day treatment program may provide fewer than the minimally  
253.6 required hours for a particular child during a billing period in which the child is transitioning  
253.7 into, or out of, the program.

253.8 (b) To be eligible for medical assistance payment, a provider entity must deliver the  
253.9 service components of children's therapeutic services and supports in compliance with the  
253.10 following requirements:

253.11 (1) psychotherapy to address the child's underlying mental health disorder must be  
253.12 documented as part of the child's ongoing treatment. A provider must deliver or arrange for  
253.13 medically necessary psychotherapy unless the child's parent or caregiver chooses not to  
253.14 receive it or the provider determines that psychotherapy is no longer medically necessary.  
253.15 When a provider determines that psychotherapy is no longer medically necessary, the  
253.16 provider must update required documentation, including but not limited to the individual  
253.17 treatment plan, the child's medical record, or other authorizations, to include the  
253.18 determination. When a provider determines that a child needs psychotherapy but  
253.19 psychotherapy cannot be delivered due to a shortage of licensed mental health professionals  
253.20 in the child's community, the provider must document the lack of access in the child's  
253.21 medical record;

253.22 (2) individual, family, or group skills training is subject to the following requirements:

253.23 (i) a mental health professional, clinical trainee, or mental health practitioner shall provide  
253.24 skills training;

253.25 (ii) skills training delivered to a child or the child's family must be targeted to the specific  
253.26 deficits or maladaptations of the child's mental health disorder and must be prescribed in  
253.27 the child's individual treatment plan;

253.28 (iii) group skills training may be provided to multiple recipients who, because of the  
253.29 nature of their emotional, behavioral, or social dysfunction, can derive mutual benefit from  
253.30 interaction in a group setting, which must be staffed as follows:

253.31 (A) one mental health professional, clinical trainee, or mental health practitioner must  
253.32 work with a group of three to eight clients; or

254.1 (B) any combination of two mental health professionals, clinical trainees, or mental  
254.2 health practitioners must work with a group of nine to 12 clients;

254.3 (iv) a mental health professional, clinical trainee, or mental health practitioner must have  
254.4 taught the psychosocial skill before a mental health behavioral aide may practice that skill  
254.5 with the client; and

254.6 (v) for group skills training, when a skills group that meets the minimum group size  
254.7 requirement temporarily falls below the minimum group size because of a group member's  
254.8 temporary absence, the provider may conduct the session for the group members in  
254.9 attendance;

254.10 (3) crisis planning to a child and family must include development of a written plan that  
254.11 anticipates the particular factors specific to the child that may precipitate a psychiatric crisis  
254.12 for the child in the near future. The written plan must document actions that the family  
254.13 should be prepared to take to resolve or stabilize a crisis, such as advance arrangements for  
254.14 direct intervention and support services to the child and the child's family. Crisis planning  
254.15 must include preparing resources designed to address abrupt or substantial changes in the  
254.16 functioning of the child or the child's family when sudden change in behavior or a loss of  
254.17 usual coping mechanisms is observed, or the child begins to present a danger to self or  
254.18 others;

254.19 (4) mental health behavioral aide services must be medically necessary treatment services,  
254.20 identified in the child's individual treatment plan.

254.21 To be eligible for medical assistance payment, mental health behavioral aide services must  
254.22 be delivered to a child who has been diagnosed with ~~an emotional disturbance or~~ a mental  
254.23 illness, as provided in subdivision 1, paragraph (a). The mental health behavioral aide must  
254.24 document the delivery of services in written progress notes. Progress notes must reflect  
254.25 implementation of the treatment strategies, as performed by the mental health behavioral  
254.26 aide and the child's responses to the treatment strategies; and

254.27 (5) mental health service plan development must be performed in consultation with the  
254.28 child's family and, when appropriate, with other key participants in the child's life by the  
254.29 child's treating mental health professional or clinical trainee or by a mental health practitioner  
254.30 and approved by the treating mental health professional. Treatment plan drafting consists  
254.31 of development, review, and revision by face-to-face or electronic communication. The  
254.32 provider must document events, including the time spent with the family and other key  
254.33 participants in the child's life to approve the individual treatment plan. Medical assistance  
254.34 covers service plan development before completion of the child's individual treatment plan.

255.1 Service plan development is covered only if a treatment plan is completed for the child. If  
255.2 upon review it is determined that a treatment plan was not completed for the child, the  
255.3 commissioner shall recover the payment for the service plan development.

255.4 Sec. 63. Minnesota Statutes 2024, section 256B.0943, subdivision 12, is amended to read:

255.5 Subd. 12. **Excluded services.** The following services are not eligible for medical  
255.6 assistance payment as children's therapeutic services and supports:

255.7 (1) service components of children's therapeutic services and supports simultaneously  
255.8 provided by more than one provider entity unless prior authorization is obtained;

255.9 (2) treatment by multiple providers within the same agency at the same clock time,  
255.10 unless one service is delivered to the child and the other service is delivered to the child's  
255.11 family or treatment team without the child present;

255.12 (3) children's therapeutic services and supports provided in violation of medical assistance  
255.13 policy in Minnesota Rules, part 9505.0220;

255.14 (4) mental health behavioral aide services provided by a personal care assistant who is  
255.15 not qualified as a mental health behavioral aide and employed by a certified children's  
255.16 therapeutic services and supports provider entity;

255.17 (5) service components of CTSS that are the responsibility of a residential or program  
255.18 license holder, including foster care providers under the terms of a service agreement or  
255.19 administrative rules governing licensure; and

255.20 (6) adjunctive activities that may be offered by a provider entity but are not otherwise  
255.21 covered by medical assistance, including:

255.22 (i) a service that is primarily recreation oriented or that is provided in a setting that is  
255.23 not medically supervised. This includes sports activities, exercise groups, activities such as  
255.24 craft hours, leisure time, social hours, meal or snack time, trips to community activities,  
255.25 and tours;

255.26 (ii) a social or educational service that does not have or cannot reasonably be expected  
255.27 to have a therapeutic outcome related to the client's ~~emotional disturbance~~ mental illness;

255.28 (iii) prevention or education programs provided to the community; and

255.29 (iv) treatment for clients with primary diagnoses of alcohol or other drug abuse.

256.1 Sec. 64. Minnesota Statutes 2024, section 256B.0943, subdivision 13, is amended to read:

256.2 Subd. 13. **Exception to excluded services.** Notwithstanding subdivision 12, up to 15  
256.3 hours of children's therapeutic services and supports provided within a six-month period to  
256.4 a child with ~~severe emotional disturbance~~ serious mental illness who is residing in a hospital;  
256.5 a residential treatment facility licensed under Minnesota Rules, parts 2960.0580 to 2960.0690;  
256.6 a psychiatric residential treatment facility under section 256B.0625, subdivision 45a; a  
256.7 regional treatment center; or other institutional group setting or who is participating in a  
256.8 program of partial hospitalization are eligible for medical assistance payment if part of the  
256.9 discharge plan.

256.10 Sec. 65. Minnesota Statutes 2024, section 256B.0945, subdivision 1, is amended to read:

256.11 Subdivision 1. **Residential services; provider qualifications.** (a) Counties must arrange  
256.12 to provide residential services for children with ~~severe emotional disturbance~~ serious mental  
256.13 illness according to sections 245.4882, 245.4885, and this section.

256.14 (b) Services must be provided by a facility that is licensed according to section 245.4882  
256.15 and administrative rules promulgated thereunder, and under contract with the county.

256.16 (c) Eligible service costs may be claimed for a facility that is located in a state that  
256.17 borders Minnesota if:

256.18 (1) the facility is the closest facility to the child's home, providing the appropriate level  
256.19 of care; and

256.20 (2) the commissioner of human services has completed an inspection of the out-of-state  
256.21 program according to the interagency agreement with the commissioner of corrections under  
256.22 section 260B.198, subdivision 11, paragraph (b), and the program has been certified by the  
256.23 commissioner of corrections under section 260B.198, subdivision 11, paragraph (a), to  
256.24 substantially meet the standards applicable to children's residential mental health treatment  
256.25 programs under Minnesota Rules, chapter 2960. Nothing in this section requires the  
256.26 commissioner of human services to enforce the background study requirements under chapter  
256.27 245C or the requirements related to prevention and investigation of alleged maltreatment  
256.28 under section 626.557 or chapter 260E. Complaints received by the commissioner of human  
256.29 services must be referred to the out-of-state licensing authority for possible follow-up.

256.30 (d) Notwithstanding paragraph (b), eligible service costs may be claimed for an  
256.31 out-of-state inpatient treatment facility if:

256.32 (1) the facility specializes in providing mental health services to children who are deaf,  
256.33 deafblind, or hard-of-hearing and who use American Sign Language as their first language;

- 257.1 (2) the facility is licensed by the state in which it is located; and
- 257.2 (3) the state in which the facility is located is a member state of the Interstate Compact
- 257.3 on Mental Health.

257.4 Sec. 66. Minnesota Statutes 2024, section 256B.0946, subdivision 6, is amended to read:

257.5 Subd. 6. **Excluded services.** (a) Services in clauses (1) to (7) are not covered under this

257.6 section and are not eligible for medical assistance payment as components of children's

257.7 intensive behavioral health services, but may be billed separately:

- 257.8 (1) inpatient psychiatric hospital treatment;
- 257.9 (2) mental health targeted case management;
- 257.10 (3) partial hospitalization;
- 257.11 (4) medication management;
- 257.12 (5) children's mental health day treatment services;
- 257.13 (6) crisis response services under section 256B.0624;
- 257.14 (7) transportation; and
- 257.15 (8) mental health certified family peer specialist services under section 256B.0616.

257.16 (b) Children receiving intensive behavioral health services are not eligible for medical

257.17 assistance reimbursement for the following services while receiving children's intensive

257.18 behavioral health services:

- 257.19 (1) psychotherapy and skills training components of children's therapeutic services and
- 257.20 supports under section 256B.0943;
- 257.21 (2) mental health behavioral aide services as defined in section 256B.0943, subdivision
- 257.22 1, paragraph ~~(h)~~ (j);
- 257.23 (3) home and community-based waiver services;
- 257.24 (4) mental health residential treatment; and
- 257.25 (5) medical assistance room and board rate, as defined in section 256B.056, subdivision
- 257.26 5d.

258.1 Sec. 67. Minnesota Statutes 2024, section 256B.0947, subdivision 3a, is amended to read:

258.2 Subd. 3a. **Required service components.** (a) Intensive nonresidential rehabilitative  
258.3 mental health services, supports, and ancillary activities that are covered by a single daily  
258.4 rate per client must include the following, as needed by the individual client:

258.5 (1) individual, family, and group psychotherapy;

258.6 (2) individual, family, and group skills training, as defined in section 256B.0943,  
258.7 subdivision 1, paragraph ~~(t)~~ (r);

258.8 (3) crisis planning as defined in section 245.4871, subdivision 9a;

258.9 (4) medication management provided by a physician, an advanced practice registered  
258.10 nurse with certification in psychiatric and mental health care, or a physician assistant;

258.11 (5) mental health case management as provided in section 256B.0625, subdivision 20;

258.12 (6) medication education services as defined in this section;

258.13 (7) care coordination by a client-specific lead worker assigned by and responsible to the  
258.14 treatment team;

258.15 (8) psychoeducation of and consultation and coordination with the client's biological,  
258.16 adoptive, or foster family and, in the case of a youth living independently, the client's  
258.17 immediate nonfamilial support network;

258.18 (9) clinical consultation to a client's employer or school or to other service agencies or  
258.19 to the courts to assist in managing the mental illness or co-occurring disorder and to develop  
258.20 client support systems;

258.21 (10) coordination with, or performance of, crisis intervention and stabilization services  
258.22 as defined in section 256B.0624;

258.23 (11) transition services;

258.24 (12) co-occurring substance use disorder treatment as defined in section 245I.02,  
258.25 subdivision 11; and

258.26 (13) housing access support that assists clients to find, obtain, retain, and move to safe  
258.27 and adequate housing. Housing access support does not provide monetary assistance for  
258.28 rent, damage deposits, or application fees.

258.29 (b) The provider shall ensure and document the following by means of performing the  
258.30 required function or by contracting with a qualified person or entity: client access to crisis

259.1 intervention services, as defined in section 256B.0624, and available 24 hours per day and  
259.2 seven days per week.

259.3 Sec. 68. Minnesota Statutes 2024, section 256B.69, subdivision 23, is amended to read:

259.4 Subd. 23. **Alternative services; elderly persons and persons with a disability.** (a) The  
259.5 commissioner may implement demonstration projects to create alternative integrated delivery  
259.6 systems for acute and long-term care services to elderly persons and persons with disabilities  
259.7 as defined in section 256B.77, subdivision 7a, that provide increased coordination, improve  
259.8 access to quality services, and mitigate future cost increases. The commissioner may seek  
259.9 federal authority to combine Medicare and Medicaid capitation payments for the purpose  
259.10 of such demonstrations and may contract with Medicare-approved special needs plans that  
259.11 are offered by a demonstration provider or by an entity that is directly or indirectly wholly  
259.12 owned or controlled by a demonstration provider to provide Medicaid services. Medicare  
259.13 funds and services shall be administered according to the terms and conditions of the federal  
259.14 contract and demonstration provisions. For the purpose of administering medical assistance  
259.15 funds, demonstrations under this subdivision are subject to subdivisions 1 to 22. The  
259.16 provisions of Minnesota Rules, parts 9500.1450 to 9500.1464, apply to these demonstrations,  
259.17 with the exceptions of parts 9500.1452, subpart 2, item B; and 9500.1457, subpart 1, items  
259.18 B and C, which do not apply to persons enrolling in demonstrations under this section. All  
259.19 enforcement and rulemaking powers available under chapters 62D, 62M, and 62Q are hereby  
259.20 granted to the commissioner of health with respect to Medicare-approved special needs  
259.21 plans with which the commissioner contracts to provide Medicaid services under this section.  
259.22 An initial open enrollment period may be provided. Persons who disenroll from  
259.23 demonstrations under this subdivision remain subject to Minnesota Rules, parts 9500.1450  
259.24 to 9500.1464. When a person is enrolled in a health plan under these demonstrations and  
259.25 the health plan's participation is subsequently terminated for any reason, the person shall  
259.26 be provided an opportunity to select a new health plan and shall have the right to change  
259.27 health plans within the first 60 days of enrollment in the second health plan. Persons required  
259.28 to participate in health plans under this section who fail to make a choice of health plan  
259.29 shall not be randomly assigned to health plans under these demonstrations. Notwithstanding  
259.30 section 256L.12, subdivision 5, and Minnesota Rules, part 9505.5220, subpart 1, item A,  
259.31 if adopted, for the purpose of demonstrations under this subdivision, the commissioner may  
259.32 contract with managed care organizations, including counties, to serve only elderly persons  
259.33 eligible for medical assistance, elderly persons with a disability, or persons with a disability  
259.34 only. For persons with a primary diagnosis of developmental disability, serious and persistent  
259.35 mental illness, or serious ~~emotional disturbance~~ mental illness in children, the commissioner

260.1 must ensure that the county authority has approved the demonstration and contracting design.  
260.2 Enrollment in these projects for persons with disabilities shall be voluntary. The  
260.3 commissioner shall not implement any demonstration project under this subdivision for  
260.4 persons with a primary diagnosis of developmental disabilities, serious and persistent mental  
260.5 illness, or serious ~~emotional disturbance~~, mental illness in children without approval of the  
260.6 county board of the county in which the demonstration is being implemented.

260.7 (b) MS 2009 Supplement [Expired, 2003 c 47 s 4; 2007 c 147 art 7 s 60]

260.8 (c) Before implementation of a demonstration project for persons with a disability, the  
260.9 commissioner must provide information to appropriate committees of the house of  
260.10 representatives and senate and must involve representatives of affected disability groups in  
260.11 the design of the demonstration projects.

260.12 (d) A nursing facility reimbursed under the alternative reimbursement methodology in  
260.13 section 256B.434 may, in collaboration with a hospital, clinic, or other health care entity  
260.14 provide services under paragraph (a). The commissioner shall amend the state plan and seek  
260.15 any federal waivers necessary to implement this paragraph.

260.16 (e) The commissioner, in consultation with the commissioners of commerce and health,  
260.17 may approve and implement programs for all-inclusive care for the elderly (PACE) according  
260.18 to federal laws and regulations governing that program and state laws or rules applicable  
260.19 to participating providers. A PACE provider is not required to be licensed or certified as a  
260.20 health plan company as defined in section 62Q.01, subdivision 4. Persons age 55 and older  
260.21 who have been screened by the county and found to be eligible for services under the elderly  
260.22 waiver or community access for disability inclusion or who are already eligible for Medicaid  
260.23 but meet level of care criteria for receipt of waiver services may choose to enroll in the  
260.24 PACE program. Medicare and Medicaid services will be provided according to this  
260.25 subdivision and federal Medicare and Medicaid requirements governing PACE providers  
260.26 and programs. PACE enrollees will receive Medicaid home and community-based services  
260.27 through the PACE provider as an alternative to services for which they would otherwise be  
260.28 eligible through home and community-based waiver programs and Medicaid State Plan  
260.29 Services. The commissioner shall establish Medicaid rates for PACE providers that do not  
260.30 exceed costs that would have been incurred under fee-for-service or other relevant managed  
260.31 care programs operated by the state.

260.32 (f) The commissioner shall seek federal approval to expand the Minnesota disability  
260.33 health options (MnDHO) program established under this subdivision in stages, first to  
260.34 regional population centers outside the seven-county metro area and then to all areas of the

261.1 state. Until July 1, 2009, expansion for MnDHO projects that include home and  
261.2 community-based services is limited to the two projects and service areas in effect on March  
261.3 1, 2006. Enrollment in integrated MnDHO programs that include home and community-based  
261.4 services shall remain voluntary. Costs for home and community-based services included  
261.5 under MnDHO must not exceed costs that would have been incurred under the fee-for-service  
261.6 program. Notwithstanding whether expansion occurs under this paragraph, in determining  
261.7 MnDHO payment rates and risk adjustment methods, the commissioner must consider the  
261.8 methods used to determine county allocations for home and community-based program  
261.9 participants. If necessary to reduce MnDHO rates to comply with the provision regarding  
261.10 MnDHO costs for home and community-based services, the commissioner shall achieve  
261.11 the reduction by maintaining the base rate for contract year 2010 for services provided under  
261.12 the community access for disability inclusion waiver at the same level as for contract year  
261.13 2009. The commissioner may apply other reductions to MnDHO rates to implement decreases  
261.14 in provider payment rates required by state law. Effective January 1, 2011, enrollment and  
261.15 operation of the MnDHO program in effect during 2010 shall cease. The commissioner may  
261.16 reopen the program provided all applicable conditions of this section are met. In developing  
261.17 program specifications for expansion of integrated programs, the commissioner shall involve  
261.18 and consult the state-level stakeholder group established in subdivision 28, paragraph (d),  
261.19 including consultation on whether and how to include home and community-based waiver  
261.20 programs. Plans to reopen MnDHO projects shall be presented to the chairs of the house of  
261.21 representatives and senate committees with jurisdiction over health and human services  
261.22 policy and finance prior to implementation.

261.23 (g) Notwithstanding section 256B.0621, health plans providing services under this section  
261.24 are responsible for home care targeted case management and relocation targeted case  
261.25 management. Services must be provided according to the terms of the waivers and contracts  
261.26 approved by the federal government.

261.27 Sec. 69. Minnesota Statutes 2024, section 256B.77, subdivision 7a, is amended to read:

261.28 Subd. 7a. **Eligible individuals.** (a) Persons are eligible for the demonstration project as  
261.29 provided in this subdivision.

261.30 (b) "Eligible individuals" means those persons living in the demonstration site who are  
261.31 eligible for medical assistance and are disabled based on a disability determination under  
261.32 section 256B.055, subdivisions 7 and 12, or who are eligible for medical assistance and  
261.33 have been diagnosed as having:

261.34 (1) serious and persistent mental illness as defined in section 245.462, subdivision 20;

262.1 (2) ~~severe emotional disturbance~~ serious mental illness as defined in section 245.4871,  
262.2 subdivision 6; or

262.3 (3) developmental disability, or being a person with a developmental disability as defined  
262.4 in section 252A.02, or a related condition as defined in section 256B.02, subdivision 11.

262.5 Other individuals may be included at the option of the county authority based on agreement  
262.6 with the commissioner.

262.7 (c) Eligible individuals include individuals in excluded time status, as defined in chapter  
262.8 256G. Enrollees in excluded time at the time of enrollment shall remain in excluded time  
262.9 status as long as they live in the demonstration site and shall be eligible for 90 days after  
262.10 placement outside the demonstration site if they move to excluded time status in a county  
262.11 within Minnesota other than their county of financial responsibility.

262.12 (d) A person who is a sexual psychopathic personality as defined in section 253D.02,  
262.13 subdivision 15, or a sexually dangerous person as defined in section 253D.02, subdivision  
262.14 16, is excluded from enrollment in the demonstration project.

262.15 Sec. 70. Minnesota Statutes 2024, section 260B.157, subdivision 3, is amended to read:

262.16 Subd. 3. **Juvenile treatment screening team.** (a) The local social services agency shall  
262.17 establish a juvenile treatment screening team to conduct screenings and prepare case plans  
262.18 under this subdivision. The team, which may be the team constituted under section 245.4885  
262.19 or 256B.092 or chapter 254B, shall consist of social workers, juvenile justice professionals,  
262.20 and persons with expertise in the treatment of juveniles who are emotionally disabled,  
262.21 chemically dependent, or have a developmental disability. The team shall involve parents  
262.22 or guardians in the screening process as appropriate. The team may be the same team as  
262.23 defined in section 260C.157, subdivision 3.

262.24 (b) If the court, prior to, or as part of, a final disposition, proposes to place a child:

262.25 (1) for the primary purpose of treatment for ~~an emotional disturbance~~ mental illness,  
262.26 and residential placement is consistent with section 260.012, a developmental disability, or  
262.27 chemical dependency in a residential treatment facility out of state or in one which is within  
262.28 the state and licensed by the commissioner of human services under chapter 245A; or

262.29 (2) in any out-of-home setting potentially exceeding 30 days in duration, including a  
262.30 post-dispositional placement in a facility licensed by the commissioner of corrections or  
262.31 human services, the court shall notify the county welfare agency. The county's juvenile  
262.32 treatment screening team must either:

263.1 (i) screen and evaluate the child and file its recommendations with the court within 14  
263.2 days of receipt of the notice; or

263.3 (ii) elect not to screen a given case, and notify the court of that decision within three  
263.4 working days.

263.5 (c) If the screening team has elected to screen and evaluate the child, the child may not  
263.6 be placed for the primary purpose of treatment for ~~an emotional disturbance~~ mental illness,  
263.7 a developmental disability, or chemical dependency, in a residential treatment facility out  
263.8 of state nor in a residential treatment facility within the state that is licensed under chapter  
263.9 245A, unless one of the following conditions applies:

263.10 (1) a treatment professional certifies that an emergency requires the placement of the  
263.11 child in a facility within the state;

263.12 (2) the screening team has evaluated the child and recommended that a residential  
263.13 placement is necessary to meet the child's treatment needs and the safety needs of the  
263.14 community, that it is a cost-effective means of meeting the treatment needs, and that it will  
263.15 be of therapeutic value to the child; or

263.16 (3) the court, having reviewed a screening team recommendation against placement,  
263.17 determines to the contrary that a residential placement is necessary. The court shall state  
263.18 the reasons for its determination in writing, on the record, and shall respond specifically to  
263.19 the findings and recommendation of the screening team in explaining why the  
263.20 recommendation was rejected. The attorney representing the child and the prosecuting  
263.21 attorney shall be afforded an opportunity to be heard on the matter.

263.22 Sec. 71. Minnesota Statutes 2024, section 260C.007, subdivision 16, is amended to read:

263.23 Subd. 16. ~~Emotionally disturbed~~ **Mental illness.** "~~Emotionally disturbed~~ Mental illness"  
263.24 means ~~emotional disturbance~~ a mental illness as described in section 245.4871, subdivision  
263.25 15.

263.26 Sec. 72. Minnesota Statutes 2024, section 260C.007, subdivision 26d, is amended to read:

263.27 Subd. 26d. **Qualified residential treatment program.** "Qualified residential treatment  
263.28 program" means a children's residential treatment program licensed under chapter 245A or  
263.29 licensed or approved by a tribe that is approved to receive foster care maintenance payments  
263.30 under section 142A.418 that:

263.31 (1) has a trauma-informed treatment model designed to address the needs of children  
263.32 with serious emotional or behavioral disorders or disturbances or mental illnesses;

264.1 (2) has registered or licensed nursing staff and other licensed clinical staff who:

264.2 (i) provide care within the scope of their practice; and

264.3 (ii) are available 24 hours per day and seven days per week;

264.4 (3) is accredited by any of the following independent, nonprofit organizations: the

264.5 Commission on Accreditation of Rehabilitation Facilities (CARF), the Joint Commission

264.6 on Accreditation of Healthcare Organizations (JCAHO), and the Council on Accreditation

264.7 (COA), or any other nonprofit accrediting organization approved by the United States

264.8 Department of Health and Human Services;

264.9 (4) if it is in the child's best interests, facilitates participation of the child's family members

264.10 in the child's treatment programming consistent with the child's out-of-home placement

264.11 plan under sections 260C.212, subdivision 1, and 260C.708;

264.12 (5) facilitates outreach to family members of the child, including siblings;

264.13 (6) documents how the facility facilitates outreach to the child's parents and relatives,

264.14 as well as documents the child's parents' and other relatives' contact information;

264.15 (7) documents how the facility includes family members in the child's treatment process,

264.16 including after the child's discharge, and how the facility maintains the child's sibling

264.17 connections; and

264.18 (8) provides the child and child's family with discharge planning and family-based

264.19 aftercare support for at least six months after the child's discharge. Aftercare support may

264.20 include clinical care consultation under section 256B.0671, subdivision 7, and mental health

264.21 certified family peer specialist services under section 256B.0616.

264.22 Sec. 73. Minnesota Statutes 2024, section 260C.007, subdivision 27b, is amended to read:

264.23 Subd. 27b. **Residential treatment facility.** "Residential treatment facility" means a

264.24 24-hour-a-day program that provides treatment for children with ~~emotional disturbance~~

264.25 mental illness, consistent with section 245.4871, subdivision 32, and includes a licensed

264.26 residential program specializing in caring 24 hours a day for children with a developmental

264.27 delay or related condition. A residential treatment facility does not include a psychiatric

264.28 residential treatment facility under section 256B.0941 or a family foster home as defined

264.29 in section 260C.007, subdivision 16b.

265.1 Sec. 74. Minnesota Statutes 2024, section 260C.157, subdivision 3, is amended to read:

265.2 Subd. 3. **Juvenile treatment screening team.** (a) The responsible social services agency  
265.3 shall establish a juvenile treatment screening team to conduct screenings under this chapter  
265.4 and chapter 260D, for a child to receive treatment for ~~an emotional disturbance~~ a mental  
265.5 illness, a developmental disability, or related condition in a residential treatment facility  
265.6 licensed by the commissioner of human services under chapter 245A, or licensed or approved  
265.7 by a tribe. A screening team is not required for a child to be in: (1) a residential facility  
265.8 specializing in prenatal, postpartum, or parenting support; (2) a facility specializing in  
265.9 high-quality residential care and supportive services to children and youth who have been  
265.10 or are at risk of becoming victims of sex trafficking or commercial sexual exploitation; (3)  
265.11 supervised settings for youth who are 18 years of age or older and living independently; or  
265.12 (4) a licensed residential family-based treatment facility for substance abuse consistent with  
265.13 section 260C.190. Screenings are also not required when a child must be placed in a facility  
265.14 due to an emotional crisis or other mental health emergency.

265.15 (b) The responsible social services agency shall conduct screenings within 15 days of a  
265.16 request for a screening, unless the screening is for the purpose of residential treatment and  
265.17 the child is enrolled in a prepaid health program under section 256B.69, in which case the  
265.18 agency shall conduct the screening within ten working days of a request. The responsible  
265.19 social services agency shall convene the juvenile treatment screening team, which may be  
265.20 constituted under section 245.4885, 254B.05, or 256B.092. The team shall consist of social  
265.21 workers; persons with expertise in the treatment of juveniles who are emotionally disturbed,  
265.22 chemically dependent, or have a developmental disability; and the child's parent, guardian,  
265.23 or permanent legal custodian. The team may include the child's relatives as defined in section  
265.24 260C.007, subdivisions 26b and 27, the child's foster care provider, and professionals who  
265.25 are a resource to the child's family such as teachers, medical or mental health providers,  
265.26 and clergy, as appropriate, consistent with the family and permanency team as defined in  
265.27 section 260C.007, subdivision 16a. Prior to forming the team, the responsible social services  
265.28 agency must consult with the child's parents, the child if the child is age 14 or older, and,  
265.29 if applicable, the child's tribe to obtain recommendations regarding which individuals to  
265.30 include on the team and to ensure that the team is family-centered and will act in the child's  
265.31 best interests. If the child, child's parents, or legal guardians raise concerns about specific  
265.32 relatives or professionals, the team should not include those individuals. This provision  
265.33 does not apply to paragraph (c).

265.34 (c) If the agency provides notice to tribes under section 260.761, and the child screened  
265.35 is an Indian child, the responsible social services agency must make a rigorous and concerted

266.1 effort to include a designated representative of the Indian child's tribe on the juvenile  
266.2 treatment screening team, unless the child's tribal authority declines to appoint a  
266.3 representative. The Indian child's tribe may delegate its authority to represent the child to  
266.4 any other federally recognized Indian tribe, as defined in section 260.755, subdivision 12.  
266.5 The provisions of the Indian Child Welfare Act of 1978, United States Code, title 25, sections  
266.6 1901 to 1963, and the Minnesota Indian Family Preservation Act, sections 260.751 to  
266.7 260.835, apply to this section.

266.8 (d) If the court, prior to, or as part of, a final disposition or other court order, proposes  
266.9 to place a child with ~~an emotional disturbance or~~ a mental illness, developmental disability,  
266.10 or related condition in residential treatment, the responsible social services agency must  
266.11 conduct a screening. If the team recommends treating the child in a qualified residential  
266.12 treatment program, the agency must follow the requirements of sections 260C.70 to  
266.13 260C.714.

266.14 The court shall ascertain whether the child is an Indian child and shall notify the  
266.15 responsible social services agency and, if the child is an Indian child, shall notify the Indian  
266.16 child's tribe as paragraph (c) requires.

266.17 (e) When the responsible social services agency is responsible for placing and caring  
266.18 for the child and the screening team recommends placing a child in a qualified residential  
266.19 treatment program as defined in section 260C.007, subdivision 26d, the agency must: (1)  
266.20 begin the assessment and processes required in section 260C.704 without delay; and (2)  
266.21 conduct a relative search according to section 260C.221 to assemble the child's family and  
266.22 permanency team under section 260C.706. Prior to notifying relatives regarding the family  
266.23 and permanency team, the responsible social services agency must consult with the child's  
266.24 parent or legal guardian, the child if the child is age 14 or older, and, if applicable, the child's  
266.25 tribe to ensure that the agency is providing notice to individuals who will act in the child's  
266.26 best interests. The child and the child's parents may identify a culturally competent qualified  
266.27 individual to complete the child's assessment. The agency shall make efforts to refer the  
266.28 assessment to the identified qualified individual. The assessment may not be delayed for  
266.29 the purpose of having the assessment completed by a specific qualified individual.

266.30 (f) When a screening team determines that a child does not need treatment in a qualified  
266.31 residential treatment program, the screening team must:

266.32 (1) document the services and supports that will prevent the child's foster care placement  
266.33 and will support the child remaining at home;

267.1 (2) document the services and supports that the agency will arrange to place the child  
267.2 in a family foster home; or

267.3 (3) document the services and supports that the agency has provided in any other setting.

267.4 (g) When the Indian child's tribe or tribal health care services provider or Indian Health  
267.5 Services provider proposes to place a child for the primary purpose of treatment for an  
267.6 ~~emotional disturbance~~ a mental illness, a developmental disability, or co-occurring ~~emotional~~  
267.7 ~~disturbance~~ mental illness and chemical dependency, the Indian child's tribe or the tribe  
267.8 delegated by the child's tribe shall submit necessary documentation to the county juvenile  
267.9 treatment screening team, which must invite the Indian child's tribe to designate a  
267.10 representative to the screening team.

267.11 (h) The responsible social services agency must conduct and document the screening in  
267.12 a format approved by the commissioner of human services.

267.13 Sec. 75. Minnesota Statutes 2024, section 260C.201, subdivision 1, is amended to read:

267.14 Subdivision 1. **Dispositions.** (a) If the court finds that the child is in need of protection  
267.15 or services or neglected and in foster care, the court shall enter an order making any of the  
267.16 following dispositions of the case:

267.17 (1) place the child under the protective supervision of the responsible social services  
267.18 agency or child-placing agency in the home of a parent of the child under conditions  
267.19 prescribed by the court directed to the correction of the child's need for protection or services:

267.20 (i) the court may order the child into the home of a parent who does not otherwise have  
267.21 legal custody of the child, however, an order under this section does not confer legal custody  
267.22 on that parent;

267.23 (ii) if the court orders the child into the home of a father who is not adjudicated, the  
267.24 father must cooperate with paternity establishment proceedings regarding the child in the  
267.25 appropriate jurisdiction as one of the conditions prescribed by the court for the child to  
267.26 continue in the father's home; and

267.27 (iii) the court may order the child into the home of a noncustodial parent with conditions  
267.28 and may also order both the noncustodial and the custodial parent to comply with the  
267.29 requirements of a case plan under subdivision 2; or

267.30 (2) transfer legal custody to one of the following:

267.31 (i) a child-placing agency; or

268.1 (ii) the responsible social services agency. In making a foster care placement of a child  
268.2 whose custody has been transferred under this subdivision, the agency shall make an  
268.3 individualized determination of how the placement is in the child's best interests using the  
268.4 placement consideration order for relatives and the best interest factors in section 260C.212,  
268.5 subdivision 2, and may include a child colocated with a parent in a licensed residential  
268.6 family-based substance use disorder treatment program under section 260C.190; or

268.7 (3) order a trial home visit without modifying the transfer of legal custody to the  
268.8 responsible social services agency under clause (2). Trial home visit means the child is  
268.9 returned to the care of the parent or guardian from whom the child was removed for a period  
268.10 not to exceed six months. During the period of the trial home visit, the responsible social  
268.11 services agency:

268.12 (i) shall continue to have legal custody of the child, which means that the agency may  
268.13 see the child in the parent's home, at school, in a child care facility, or other setting as the  
268.14 agency deems necessary and appropriate;

268.15 (ii) shall continue to have the ability to access information under section 260C.208;

268.16 (iii) shall continue to provide appropriate services to both the parent and the child during  
268.17 the period of the trial home visit;

268.18 (iv) without previous court order or authorization, may terminate the trial home visit in  
268.19 order to protect the child's health, safety, or welfare and may remove the child to foster care;

268.20 (v) shall advise the court and parties within three days of the termination of the trial  
268.21 home visit when a visit is terminated by the responsible social services agency without a  
268.22 court order; and

268.23 (vi) shall prepare a report for the court when the trial home visit is terminated whether  
268.24 by the agency or court order that describes the child's circumstances during the trial home  
268.25 visit and recommends appropriate orders, if any, for the court to enter to provide for the  
268.26 child's safety and stability. In the event a trial home visit is terminated by the agency by  
268.27 removing the child to foster care without prior court order or authorization, the court shall  
268.28 conduct a hearing within ten days of receiving notice of the termination of the trial home  
268.29 visit by the agency and shall order disposition under this subdivision or commence  
268.30 permanency proceedings under sections 260C.503 to 260C.515. The time period for the  
268.31 hearing may be extended by the court for good cause shown and if it is in the best interests  
268.32 of the child as long as the total time the child spends in foster care without a permanency  
268.33 hearing does not exceed 12 months;

269.1 (4) if the child has been adjudicated as a child in need of protection or services because  
269.2 the child is in need of special services or care to treat or ameliorate a physical or mental  
269.3 disability or ~~emotional disturbance~~ a mental illness as defined in section 245.4871,  
269.4 subdivision 15, the court may order the child's parent, guardian, or custodian to provide it.  
269.5 The court may order the child's health plan company to provide mental health services to  
269.6 the child. Section 62Q.535 applies to an order for mental health services directed to the  
269.7 child's health plan company. If the health plan, parent, guardian, or custodian fails or is  
269.8 unable to provide this treatment or care, the court may order it provided. Absent specific  
269.9 written findings by the court that the child's disability is the result of abuse or neglect by  
269.10 the child's parent or guardian, the court shall not transfer legal custody of the child for the  
269.11 purpose of obtaining special treatment or care solely because the parent is unable to provide  
269.12 the treatment or care. If the court's order for mental health treatment is based on a diagnosis  
269.13 made by a treatment professional, the court may order that the diagnosing professional not  
269.14 provide the treatment to the child if it finds that such an order is in the child's best interests;  
269.15 or

269.16 (5) if the court believes that the child has sufficient maturity and judgment and that it is  
269.17 in the best interests of the child, the court may order a child 16 years old or older to be  
269.18 allowed to live independently, either alone or with others as approved by the court under  
269.19 supervision the court considers appropriate, if the county board, after consultation with the  
269.20 court, has specifically authorized this dispositional alternative for a child.

269.21 (b) If the child was adjudicated in need of protection or services because the child is a  
269.22 runaway or habitual truant, the court may order any of the following dispositions in addition  
269.23 to or as alternatives to the dispositions authorized under paragraph (a):

269.24 (1) counsel the child or the child's parents, guardian, or custodian;

269.25 (2) place the child under the supervision of a probation officer or other suitable person  
269.26 in the child's own home under conditions prescribed by the court, including reasonable rules  
269.27 for the child's conduct and the conduct of the parents, guardian, or custodian, designed for  
269.28 the physical, mental, and moral well-being and behavior of the child;

269.29 (3) subject to the court's supervision, transfer legal custody of the child to one of the  
269.30 following:

269.31 (i) a reputable person of good moral character. No person may receive custody of two  
269.32 or more unrelated children unless licensed to operate a residential program under sections  
269.33 245A.01 to 245A.16; or

270.1 (ii) a county probation officer for placement in a group foster home established under  
270.2 the direction of the juvenile court and licensed pursuant to section 241.021;

270.3 (4) require the child to pay a fine of up to \$100. The court shall order payment of the  
270.4 fine in a manner that will not impose undue financial hardship upon the child;

270.5 (5) require the child to participate in a community service project;

270.6 (6) order the child to undergo a chemical dependency evaluation and, if warranted by  
270.7 the evaluation, order participation by the child in a drug awareness program or an inpatient  
270.8 or outpatient chemical dependency treatment program;

270.9 (7) if the court believes that it is in the best interests of the child or of public safety that  
270.10 the child's driver's license or instruction permit be canceled, the court may order the  
270.11 commissioner of public safety to cancel the child's license or permit for any period up to  
270.12 the child's 18th birthday. If the child does not have a driver's license or permit, the court  
270.13 may order a denial of driving privileges for any period up to the child's 18th birthday. The  
270.14 court shall forward an order issued under this clause to the commissioner, who shall cancel  
270.15 the license or permit or deny driving privileges without a hearing for the period specified  
270.16 by the court. At any time before the expiration of the period of cancellation or denial, the  
270.17 court may, for good cause, order the commissioner of public safety to allow the child to  
270.18 apply for a license or permit, and the commissioner shall so authorize;

270.19 (8) order that the child's parent or legal guardian deliver the child to school at the  
270.20 beginning of each school day for a period of time specified by the court; or

270.21 (9) require the child to perform any other activities or participate in any other treatment  
270.22 programs deemed appropriate by the court.

270.23 To the extent practicable, the court shall enter a disposition order the same day it makes  
270.24 a finding that a child is in need of protection or services or neglected and in foster care, but  
270.25 in no event more than 15 days after the finding unless the court finds that the best interests  
270.26 of the child will be served by granting a delay. If the child was under eight years of age at  
270.27 the time the petition was filed, the disposition order must be entered within ten days of the  
270.28 finding and the court may not grant a delay unless good cause is shown and the court finds  
270.29 the best interests of the child will be served by the delay.

270.30 (c) If a child who is 14 years of age or older is adjudicated in need of protection or  
270.31 services because the child is a habitual truant and truancy procedures involving the child  
270.32 were previously dealt with by a school attendance review board or county attorney mediation  
270.33 program under section 260A.06 or 260A.07, the court shall order a cancellation or denial

271.1 of driving privileges under paragraph (b), clause (7), for any period up to the child's 18th  
271.2 birthday.

271.3 (d) In the case of a child adjudicated in need of protection or services because the child  
271.4 has committed domestic abuse and been ordered excluded from the child's parent's home,  
271.5 the court shall dismiss jurisdiction if the court, at any time, finds the parent is able or willing  
271.6 to provide an alternative safe living arrangement for the child as defined in paragraph (f).

271.7 (e) When a parent has complied with a case plan ordered under subdivision 6 and the  
271.8 child is in the care of the parent, the court may order the responsible social services agency  
271.9 to monitor the parent's continued ability to maintain the child safely in the home under such  
271.10 terms and conditions as the court determines appropriate under the circumstances.

271.11 (f) For the purposes of this subdivision, "alternative safe living arrangement" means a  
271.12 living arrangement for a child proposed by a petitioning parent or guardian if a court excludes  
271.13 the minor from the parent's or guardian's home that is separate from the victim of domestic  
271.14 abuse and safe for the child respondent. A living arrangement proposed by a petitioning  
271.15 parent or guardian is presumed to be an alternative safe living arrangement absent information  
271.16 to the contrary presented to the court. In evaluating any proposed living arrangement, the  
271.17 court shall consider whether the arrangement provides the child with necessary food, clothing,  
271.18 shelter, and education in a safe environment. Any proposed living arrangement that would  
271.19 place the child in the care of an adult who has been physically or sexually violent is presumed  
271.20 unsafe.

271.21 Sec. 76. Minnesota Statutes 2024, section 260C.201, subdivision 2, is amended to read:

271.22 Subd. 2. **Written findings.** (a) Any order for a disposition authorized under this section  
271.23 shall contain written findings of fact to support the disposition and case plan ordered and  
271.24 shall also set forth in writing the following information:

271.25 (1) why the best interests and safety of the child are served by the disposition and case  
271.26 plan ordered;

271.27 (2) what alternative dispositions or services under the case plan were considered by the  
271.28 court and why such dispositions or services were not appropriate in the instant case;

271.29 (3) when legal custody of the child is transferred, the appropriateness of the particular  
271.30 placement made or to be made by the placing agency using the relative and sibling placement  
271.31 considerations and best interest factors in section 260C.212, subdivision 2, or the  
271.32 appropriateness of a child colocated with a parent in a licensed residential family-based  
271.33 substance use disorder treatment program under section 260C.190;

272.1 (4) whether reasonable efforts to finalize the permanent plan for the child consistent  
272.2 with section 260.012 were made including reasonable efforts:

272.3 (i) to prevent the child's placement and to reunify the child with the parent or guardian  
272.4 from whom the child was removed at the earliest time consistent with the child's safety.

272.5 The court's findings must include a brief description of what preventive and reunification  
272.6 efforts were made and why further efforts could not have prevented or eliminated the  
272.7 necessity of removal or that reasonable efforts were not required under section 260.012 or  
272.8 260C.178, subdivision 1;

272.9 (ii) to identify and locate any noncustodial or nonresident parent of the child and to  
272.10 assess such parent's ability to provide day-to-day care of the child, and, where appropriate,  
272.11 provide services necessary to enable the noncustodial or nonresident parent to safely provide  
272.12 day-to-day care of the child as required under section 260C.219, unless such services are  
272.13 not required under section 260.012 or 260C.178, subdivision 1. The court's findings must  
272.14 include a description of the agency's efforts to:

272.15 (A) identify and locate the child's noncustodial or nonresident parent;

272.16 (B) assess the noncustodial or nonresident parent's ability to provide day-to-day care of  
272.17 the child; and

272.18 (C) if appropriate, provide services necessary to enable the noncustodial or nonresident  
272.19 parent to safely provide the child's day-to-day care, including efforts to engage the  
272.20 noncustodial or nonresident parent in assuming care and responsibility of the child;

272.21 (iii) to make the diligent search for relatives and provide the notices required under  
272.22 section 260C.221; a finding made pursuant to a hearing under section 260C.202 that the  
272.23 agency has made diligent efforts to conduct a relative search and has appropriately engaged  
272.24 relatives who responded to the notice under section 260C.221 and other relatives, who came  
272.25 to the attention of the agency after notice under section 260C.221 was sent, in placement  
272.26 and case planning decisions fulfills the requirement of this item;

272.27 (iv) to identify and make a foster care placement of the child, considering the order in  
272.28 section 260C.212, subdivision 2, paragraph (a), in the home of an unlicensed relative,  
272.29 according to the requirements of section 142B.06, a licensed relative, or other licensed foster  
272.30 care provider, who will commit to being the permanent legal parent or custodian for the  
272.31 child in the event reunification cannot occur, but who will actively support the reunification  
272.32 plan for the child. If the court finds that the agency has not appropriately considered relatives  
272.33 for placement of the child, the court shall order the agency to comply with section 260C.212,

273.1 subdivision 2, paragraph (a). The court may order the agency to continue considering  
273.2 relatives for placement of the child regardless of the child's current placement setting; and  
273.3 (v) to place siblings together in the same home or to ensure visitation is occurring when  
273.4 siblings are separated in foster care placement and visitation is in the siblings' best interests  
273.5 under section 260C.212, subdivision 2, paragraph (d); and

273.6 (5) if the child has been adjudicated as a child in need of protection or services because  
273.7 the child is in need of special services or care to treat or ameliorate a mental disability or  
273.8 ~~emotional disturbance~~ a mental illness as defined in section 245.4871, subdivision 15, the  
273.9 written findings shall also set forth:

273.10 (i) whether the child has mental health needs that must be addressed by the case plan;

273.11 (ii) what consideration was given to the diagnostic and functional assessments performed  
273.12 by the child's mental health professional and to health and mental health care professionals'  
273.13 treatment recommendations;

273.14 (iii) what consideration was given to the requests or preferences of the child's parent or  
273.15 guardian with regard to the child's interventions, services, or treatment; and

273.16 (iv) what consideration was given to the cultural appropriateness of the child's treatment  
273.17 or services.

273.18 (b) If the court finds that the social services agency's preventive or reunification efforts  
273.19 have not been reasonable but that further preventive or reunification efforts could not permit  
273.20 the child to safely remain at home, the court may nevertheless authorize or continue the  
273.21 removal of the child.

273.22 (c) If the child has been identified by the responsible social services agency as the subject  
273.23 of concurrent permanency planning, the court shall review the reasonable efforts of the  
273.24 agency to develop a permanency plan for the child that includes a primary plan that is for  
273.25 reunification with the child's parent or guardian and a secondary plan that is for an alternative,  
273.26 legally permanent home for the child in the event reunification cannot be achieved in a  
273.27 timely manner.

273.28 Sec. 77. Minnesota Statutes 2024, section 260C.301, subdivision 4, is amended to read:

273.29 Subd. 4. **Current foster care children.** Except for cases where the child is in placement  
273.30 due solely to the child's developmental disability or ~~emotional disturbance~~ a mental illness,  
273.31 where custody has not been transferred to the responsible social services agency, and where  
273.32 the court finds compelling reasons to continue placement, the county attorney shall file a

274.1 termination of parental rights petition or a petition to transfer permanent legal and physical  
274.2 custody to a relative under section 260C.515, subdivision 4, for all children who have been  
274.3 in out-of-home care for 15 of the most recent 22 months. This requirement does not apply  
274.4 if there is a compelling reason approved by the court for determining that filing a termination  
274.5 of parental rights petition or other permanency petition would not be in the best interests  
274.6 of the child or if the responsible social services agency has not provided reasonable efforts  
274.7 necessary for the safe return of the child, if reasonable efforts are required.

274.8 Sec. 78. Minnesota Statutes 2024, section 260D.01, is amended to read:

274.9 **260D.01 CHILD IN VOLUNTARY FOSTER CARE FOR TREATMENT.**

274.10 (a) Sections 260D.01 to 260D.10, may be cited as the "child in voluntary foster care for  
274.11 treatment" provisions of the Juvenile Court Act.

274.12 (b) The juvenile court has original and exclusive jurisdiction over a child in voluntary  
274.13 foster care for treatment upon the filing of a report or petition required under this chapter.  
274.14 All obligations of the responsible social services agency to a child and family in foster care  
274.15 contained in chapter 260C not inconsistent with this chapter are also obligations of the  
274.16 agency with regard to a child in foster care for treatment under this chapter.

274.17 (c) This chapter shall be construed consistently with the mission of the children's mental  
274.18 health service system as set out in section 245.487, subdivision 3, and the duties of an agency  
274.19 under sections 256B.092 and 260C.157 and Minnesota Rules, parts 9525.0004 to 9525.0016,  
274.20 to meet the needs of a child with a developmental disability or related condition. This  
274.21 chapter:

274.22 (1) establishes voluntary foster care through a voluntary foster care agreement as the  
274.23 means for an agency and a parent to provide needed treatment when the child must be in  
274.24 foster care to receive necessary treatment for ~~an emotional disturbance or~~ a mental illness,  
274.25 developmental disability, or related condition;

274.26 (2) establishes court review requirements for a child in voluntary foster care for treatment  
274.27 due to ~~emotional disturbance or~~ a mental illness, developmental disability, or a related  
274.28 condition;

274.29 (3) establishes the ongoing responsibility of the parent as legal custodian to visit the  
274.30 child, to plan together with the agency for the child's treatment needs, to be available and  
274.31 accessible to the agency to make treatment decisions, and to obtain necessary medical,  
274.32 dental, and other care for the child;

275.1 (4) applies to voluntary foster care when the child's parent and the agency agree that the  
275.2 child's treatment needs require foster care either:

275.3 (i) due to a level of care determination by the agency's screening team informed by the  
275.4 child's diagnostic and functional assessment under section 245.4885; or

275.5 (ii) due to a determination regarding the level of services needed by the child by the  
275.6 responsible social services agency's screening team under section 256B.092, and Minnesota  
275.7 Rules, parts 9525.0004 to 9525.0016; and

275.8 (5) includes the requirements for a child's placement in sections 260C.70 to 260C.714,  
275.9 when the juvenile treatment screening team recommends placing a child in a qualified  
275.10 residential treatment program, except as modified by this chapter.

275.11 (d) This chapter does not apply when there is a current determination under chapter  
275.12 260E that the child requires child protective services or when the child is in foster care for  
275.13 any reason other than treatment for the child's ~~emotional disturbance or~~ mental illness,  
275.14 developmental disability<sub>2</sub> or related condition. When there is a determination under chapter  
275.15 260E that the child requires child protective services based on an assessment that there are  
275.16 safety and risk issues for the child that have not been mitigated through the parent's  
275.17 engagement in services or otherwise, or when the child is in foster care for any reason other  
275.18 than the child's ~~emotional disturbance or~~ mental illness, developmental disability<sub>2</sub> or related  
275.19 condition, the provisions of chapter 260C apply.

275.20 (e) The paramount consideration in all proceedings concerning a child in voluntary foster  
275.21 care for treatment is the safety, health, and the best interests of the child. The purpose of  
275.22 this chapter is:

275.23 (1) to ensure that a child with a disability is provided the services necessary to treat or  
275.24 ameliorate the symptoms of the child's disability;

275.25 (2) to preserve and strengthen the child's family ties whenever possible and in the child's  
275.26 best interests, approving the child's placement away from the child's parents only when the  
275.27 child's need for care or treatment requires out-of-home placement and the child cannot be  
275.28 maintained in the home of the parent; and

275.29 (3) to ensure that the child's parent retains legal custody of the child and associated  
275.30 decision-making authority unless the child's parent willfully fails or is unable to make  
275.31 decisions that meet the child's safety, health, and best interests. The court may not find that  
275.32 the parent willfully fails or is unable to make decisions that meet the child's needs solely  
275.33 because the parent disagrees with the agency's choice of foster care facility, unless the

276.1 agency files a petition under chapter 260C, and establishes by clear and convincing evidence  
276.2 that the child is in need of protection or services.

276.3 (f) The legal parent-child relationship shall be supported under this chapter by maintaining  
276.4 the parent's legal authority and responsibility for ongoing planning for the child and by the  
276.5 agency's assisting the parent, when necessary, to exercise the parent's ongoing right and  
276.6 obligation to visit or to have reasonable contact with the child. Ongoing planning means:

276.7 (1) actively participating in the planning and provision of educational services, medical,  
276.8 and dental care for the child;

276.9 (2) actively planning and participating with the agency and the foster care facility for  
276.10 the child's treatment needs;

276.11 (3) planning to meet the child's need for safety, stability, and permanency, and the child's  
276.12 need to stay connected to the child's family and community;

276.13 (4) engaging with the responsible social services agency to ensure that the family and  
276.14 permanency team under section 260C.706 consists of appropriate family members. For  
276.15 purposes of voluntary placement of a child in foster care for treatment under chapter 260D,  
276.16 prior to forming the child's family and permanency team, the responsible social services  
276.17 agency must consult with the child's parent or legal guardian, the child if the child is 14  
276.18 years of age or older, and, if applicable, the child's Tribe to obtain recommendations regarding  
276.19 which individuals to include on the team and to ensure that the team is family-centered and  
276.20 will act in the child's best interests. If the child, child's parents, or legal guardians raise  
276.21 concerns about specific relatives or professionals, the team should not include those  
276.22 individuals unless the individual is a treating professional or an important connection to the  
276.23 youth as outlined in the case or crisis plan; and

276.24 (5) for a voluntary placement under this chapter in a qualified residential treatment  
276.25 program, as defined in section 260C.007, subdivision 26d, for purposes of engaging in a  
276.26 relative search as provided in section 260C.221, the county agency must consult with the  
276.27 child's parent or legal guardian, the child if the child is 14 years of age or older, and, if  
276.28 applicable, the child's Tribe to obtain recommendations regarding which adult relatives the  
276.29 county agency should notify. If the child, child's parents, or legal guardians raise concerns  
276.30 about specific relatives, the county agency should not notify those relatives.

276.31 (g) The provisions of section 260.012 to ensure placement prevention, family  
276.32 reunification, and all active and reasonable effort requirements of that section apply.

277.1 Sec. 79. Minnesota Statutes 2024, section 260D.02, subdivision 5, is amended to read:

277.2 Subd. 5. **Child in voluntary foster care for treatment.** "Child in voluntary foster care  
277.3 for treatment" means a child with ~~emotional disturbance~~ a mental illness or developmental  
277.4 disability, or who has a related condition and is in foster care under a voluntary foster care  
277.5 agreement between the child's parent and the agency due to concurrence between the agency  
277.6 and the parent when it is determined that foster care is medically necessary:

277.7 (1) due to a determination by the agency's screening team based on its review of the  
277.8 diagnostic and functional assessment under section 245.4885; or

277.9 (2) due to a determination by the agency's screening team under section 256B.092 and  
277.10 Minnesota Rules, parts 9525.0004 to 9525.0016.

277.11 A child is not in voluntary foster care for treatment under this chapter when there is a  
277.12 current determination under chapter 260E that the child requires child protective services  
277.13 or when the child is in foster care for any reason other than the child's ~~emotional or~~ mental  
277.14 illness, developmental disability, or related condition.

277.15 Sec. 80. Minnesota Statutes 2024, section 260D.02, subdivision 9, is amended to read:

277.16 Subd. 9. ~~Emotional disturbance~~ Mental illness. "~~Emotional disturbance~~ Mental illness"  
277.17 means ~~emotional disturbance~~ a mental illness as described in section 245.4871, subdivision  
277.18 15.

277.19 Sec. 81. Minnesota Statutes 2024, section 260D.03, subdivision 1, is amended to read:

277.20 Subdivision 1. **Voluntary foster care.** When the agency's screening team, based upon  
277.21 the diagnostic and functional assessment under section 245.4885 or medical necessity  
277.22 screenings under section 256B.092, subdivision 7, determines the child's need for treatment  
277.23 due to ~~emotional disturbance or~~ a mental illness, developmental disability, or related condition  
277.24 requires foster care placement of the child, a voluntary foster care agreement between the  
277.25 child's parent and the agency gives the agency legal authority to place the child in foster  
277.26 care.

278.1 Sec. 82. Minnesota Statutes 2024, section 260D.04, is amended to read:

278.2 **260D.04 REQUIRED INFORMATION FOR A CHILD IN VOLUNTARY FOSTER**  
278.3 **CARE FOR TREATMENT.**

278.4 An agency with authority to place a child in voluntary foster care for treatment due to  
278.5 ~~emotional disturbance or a mental illness~~, developmental disability<sub>2</sub> or related condition;  
278.6 shall inform the child, age 12 or older, of the following:

278.7 (1) the child has the right to be consulted in the preparation of the out-of-home placement  
278.8 plan required under section 260C.212, subdivision 1, and the administrative review required  
278.9 under section 260C.203;

278.10 (2) the child has the right to visit the parent and the right to visit the child's siblings as  
278.11 determined safe and appropriate by the parent and the agency;

278.12 (3) if the child disagrees with the foster care facility or services provided under the  
278.13 out-of-home placement plan required under section 260C.212, subdivision 1, the agency  
278.14 shall include information about the nature of the child's disagreement and, to the extent  
278.15 possible, the agency's understanding of the basis of the child's disagreement in the information  
278.16 provided to the court in the report required under section 260D.06; and

278.17 (4) the child has the rights established under Minnesota Rules, part 2960.0050, as a  
278.18 resident of a facility licensed by the state.

278.19 Sec. 83. Minnesota Statutes 2024, section 260D.06, subdivision 2, is amended to read:

278.20 Subd. 2. **Agency report to court; court review.** The agency shall obtain judicial review  
278.21 by reporting to the court according to the following procedures:

278.22 (a) A written report shall be forwarded to the court within 165 days of the date of the  
278.23 voluntary placement agreement. The written report shall contain or have attached:

278.24 (1) a statement of facts that necessitate the child's foster care placement;

278.25 (2) the child's name, date of birth, race, gender, and current address;

278.26 (3) the names, race, date of birth, residence, and post office addresses of the child's  
278.27 parents or legal custodian;

278.28 (4) a statement regarding the child's eligibility for membership or enrollment in an Indian  
278.29 tribe and the agency's compliance with applicable provisions of sections 260.751 to 260.835;

278.30 (5) the names and addresses of the foster parents or chief administrator of the facility in  
278.31 which the child is placed, if the child is not in a family foster home or group home;

279.1 (6) a copy of the out-of-home placement plan required under section 260C.212,  
279.2 subdivision 1;

279.3 (7) a written summary of the proceedings of any administrative review required under  
279.4 section 260C.203;

279.5 (8) evidence as specified in section 260C.712 when a child is placed in a qualified  
279.6 residential treatment program as defined in section 260C.007, subdivision 26d; and

279.7 (9) any other information the agency, parent or legal custodian, the child or the foster  
279.8 parent, or other residential facility wants the court to consider.

279.9 (b) In the case of a child in placement due to ~~emotional disturbance~~ a mental illness, the  
279.10 written report shall include as an attachment, the child's individual treatment plan developed  
279.11 by the child's treatment professional, as provided in section 245.4871, subdivision 21, or  
279.12 the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph  
279.13 (e).

279.14 (c) In the case of a child in placement due to developmental disability or a related  
279.15 condition, the written report shall include as an attachment, the child's individual service  
279.16 plan, as provided in section 256B.092, subdivision 1b; the child's individual program plan,  
279.17 as provided in Minnesota Rules, part 9525.0004, subpart 11; the child's waiver care plan;  
279.18 or the child's standard written plan, as provided in section 125A.023, subdivision 3, paragraph  
279.19 (e).

279.20 (d) The agency must inform the child, age 12 or older, the child's parent, and the foster  
279.21 parent or foster care facility of the reporting and court review requirements of this section  
279.22 and of their right to submit information to the court:

279.23 (1) if the child or the child's parent or the foster care provider wants to send information  
279.24 to the court, the agency shall advise those persons of the reporting date and the date by  
279.25 which the agency must receive the information they want forwarded to the court so the  
279.26 agency is timely able submit it with the agency's report required under this subdivision;

279.27 (2) the agency must also inform the child, age 12 or older, the child's parent, and the  
279.28 foster care facility that they have the right to be heard in person by the court and how to  
279.29 exercise that right;

279.30 (3) the agency must also inform the child, age 12 or older, the child's parent, and the  
279.31 foster care provider that an in-court hearing will be held if requested by the child, the parent,  
279.32 or the foster care provider; and

280.1 (4) if, at the time required for the report under this section, a child, age 12 or older,  
280.2 disagrees about the foster care facility or services provided under the out-of-home placement  
280.3 plan required under section 260C.212, subdivision 1, the agency shall include information  
280.4 regarding the child's disagreement, and to the extent possible, the basis for the child's  
280.5 disagreement in the report required under this section.

280.6 (e) After receiving the required report, the court has jurisdiction to make the following  
280.7 determinations and must do so within ten days of receiving the forwarded report, whether  
280.8 a hearing is requested:

280.9 (1) whether the voluntary foster care arrangement is in the child's best interests;

280.10 (2) whether the parent and agency are appropriately planning for the child; and

280.11 (3) in the case of a child age 12 or older, who disagrees with the foster care facility or  
280.12 services provided under the out-of-home placement plan, whether it is appropriate to appoint  
280.13 counsel and a guardian ad litem for the child using standards and procedures under section  
280.14 260C.163.

280.15 (f) Unless requested by a parent, representative of the foster care facility, or the child,  
280.16 no in-court hearing is required in order for the court to make findings and issue an order as  
280.17 required in paragraph (e).

280.18 (g) If the court finds the voluntary foster care arrangement is in the child's best interests  
280.19 and that the agency and parent are appropriately planning for the child, the court shall issue  
280.20 an order containing explicit, individualized findings to support its determination. The  
280.21 individualized findings shall be based on the agency's written report and other materials  
280.22 submitted to the court. The court may make this determination notwithstanding the child's  
280.23 disagreement, if any, reported under paragraph (d).

280.24 (h) The court shall send a copy of the order to the county attorney, the agency, parent,  
280.25 child, age 12 or older, and the foster parent or foster care facility.

280.26 (i) The court shall also send the parent, the child, age 12 or older, the foster parent, or  
280.27 representative of the foster care facility notice of the permanency review hearing required  
280.28 under section 260D.07, paragraph (e).

280.29 (j) If the court finds continuing the voluntary foster care arrangement is not in the child's  
280.30 best interests or that the agency or the parent are not appropriately planning for the child,  
280.31 the court shall notify the agency, the parent, the foster parent or foster care facility, the child,  
280.32 age 12 or older, and the county attorney of the court's determinations and the basis for the

281.1 court's determinations. In this case, the court shall set the matter for hearing and appoint a  
281.2 guardian ad litem for the child under section 260C.163, subdivision 5.

281.3 Sec. 84. Minnesota Statutes 2024, section 260D.07, is amended to read:

281.4 **260D.07 REQUIRED PERMANENCY REVIEW HEARING.**

281.5 (a) When the court has found that the voluntary arrangement is in the child's best interests  
281.6 and that the agency and parent are appropriately planning for the child pursuant to the report  
281.7 submitted under section 260D.06, and the child continues in voluntary foster care as defined  
281.8 in section 260D.02, subdivision 10, for 13 months from the date of the voluntary foster care  
281.9 agreement, or has been in placement for 15 of the last 22 months, the agency must:

281.10 (1) terminate the voluntary foster care agreement and return the child home; or

281.11 (2) determine whether there are compelling reasons to continue the voluntary foster care  
281.12 arrangement and, if the agency determines there are compelling reasons, seek judicial  
281.13 approval of its determination; or

281.14 (3) file a petition for the termination of parental rights.

281.15 (b) When the agency is asking for the court's approval of its determination that there are  
281.16 compelling reasons to continue the child in the voluntary foster care arrangement, the agency  
281.17 shall file a "Petition for Permanency Review Regarding a Child in Voluntary Foster Care  
281.18 for Treatment" and ask the court to proceed under this section.

281.19 (c) The "Petition for Permanency Review Regarding a Child in Voluntary Foster Care  
281.20 for Treatment" shall be drafted or approved by the county attorney and be under oath. The  
281.21 petition shall include:

281.22 (1) the date of the voluntary placement agreement;

281.23 (2) whether the petition is due to the child's developmental disability or ~~emotional~~  
281.24 ~~disturbance~~ mental illness;

281.25 (3) the plan for the ongoing care of the child and the parent's participation in the plan;

281.26 (4) a description of the parent's visitation and contact with the child;

281.27 (5) the date of the court finding that the foster care placement was in the best interests  
281.28 of the child, if required under section 260D.06, or the date the agency filed the motion under  
281.29 section 260D.09, paragraph (b);

281.30 (6) the agency's reasonable efforts to finalize the permanent plan for the child, including  
281.31 returning the child to the care of the child's family;

282.1 (7) a citation to this chapter as the basis for the petition; and

282.2 (8) evidence as specified in section 260C.712 when a child is placed in a qualified  
282.3 residential treatment program as defined in section 260C.007, subdivision 26d.

282.4 (d) An updated copy of the out-of-home placement plan required under section 260C.212,  
282.5 subdivision 1, shall be filed with the petition.

282.6 (e) The court shall set the date for the permanency review hearing no later than 14 months  
282.7 after the child has been in placement or within 30 days of the petition filing date when the  
282.8 child has been in placement 15 of the last 22 months. The court shall serve the petition  
282.9 together with a notice of hearing by United States mail on the parent, the child age 12 or  
282.10 older, the child's guardian ad litem, if one has been appointed, the agency, the county  
282.11 attorney, and counsel for any party.

282.12 (f) The court shall conduct the permanency review hearing on the petition no later than  
282.13 14 months after the date of the voluntary placement agreement, within 30 days of the filing  
282.14 of the petition when the child has been in placement 15 of the last 22 months, or within 15  
282.15 days of a motion to terminate jurisdiction and to dismiss an order for foster care under  
282.16 chapter 260C, as provided in section 260D.09, paragraph (b).

282.17 (g) At the permanency review hearing, the court shall:

282.18 (1) inquire of the parent if the parent has reviewed the "Petition for Permanency Review  
282.19 Regarding a Child in Voluntary Foster Care for Treatment," whether the petition is accurate,  
282.20 and whether the parent agrees to the continued voluntary foster care arrangement as being  
282.21 in the child's best interests;

282.22 (2) inquire of the parent if the parent is satisfied with the agency's reasonable efforts to  
282.23 finalize the permanent plan for the child, including whether there are services available and  
282.24 accessible to the parent that might allow the child to safely be with the child's family;

282.25 (3) inquire of the parent if the parent consents to the court entering an order that:

282.26 (i) approves the responsible agency's reasonable efforts to finalize the permanent plan  
282.27 for the child, which includes ongoing future planning for the safety, health, and best interests  
282.28 of the child; and

282.29 (ii) approves the responsible agency's determination that there are compelling reasons  
282.30 why the continued voluntary foster care arrangement is in the child's best interests; and

282.31 (4) inquire of the child's guardian ad litem and any other party whether the guardian or  
282.32 the party agrees that:

283.1 (i) the court should approve the responsible agency's reasonable efforts to finalize the  
283.2 permanent plan for the child, which includes ongoing and future planning for the safety,  
283.3 health, and best interests of the child; and

283.4 (ii) the court should approve of the responsible agency's determination that there are  
283.5 compelling reasons why the continued voluntary foster care arrangement is in the child's  
283.6 best interests.

283.7 (h) At a permanency review hearing under this section, the court may take the following  
283.8 actions based on the contents of the sworn petition and the consent of the parent:

283.9 (1) approve the agency's compelling reasons that the voluntary foster care arrangement  
283.10 is in the best interests of the child; and

283.11 (2) find that the agency has made reasonable efforts to finalize the permanent plan for  
283.12 the child.

283.13 (i) A child, age 12 or older, may object to the agency's request that the court approve its  
283.14 compelling reasons for the continued voluntary arrangement and may be heard on the reasons  
283.15 for the objection. Notwithstanding the child's objection, the court may approve the agency's  
283.16 compelling reasons and the voluntary arrangement.

283.17 (j) If the court does not approve the voluntary arrangement after hearing from the child  
283.18 or the child's guardian ad litem, the court shall dismiss the petition. In this case, either:

283.19 (1) the child must be returned to the care of the parent; or

283.20 (2) the agency must file a petition under section 260C.141, asking for appropriate relief  
283.21 under sections 260C.301 or 260C.503 to 260C.521.

283.22 (k) When the court approves the agency's compelling reasons for the child to continue  
283.23 in voluntary foster care for treatment, and finds that the agency has made reasonable efforts  
283.24 to finalize a permanent plan for the child, the court shall approve the continued voluntary  
283.25 foster care arrangement, and continue the matter under the court's jurisdiction for the purposes  
283.26 of reviewing the child's placement every 12 months while the child is in foster care.

283.27 (l) A finding that the court approves the continued voluntary placement means the agency  
283.28 has continued legal authority to place the child while a voluntary placement agreement  
283.29 remains in effect. The parent or the agency may terminate a voluntary agreement as provided  
283.30 in section 260D.10. Termination of a voluntary foster care placement of an Indian child is  
283.31 governed by section 260.765, subdivision 4.

284.1 Sec. 85. Minnesota Statutes 2024, section 260E.11, subdivision 3, is amended to read:

284.2 Subd. 3. **Report to medical examiner or coroner; notification to local agency and**  
284.3 **law enforcement; report ombudsman.** (a) A person mandated to report maltreatment who  
284.4 knows or has reason to believe a child has died as a result of maltreatment shall report that  
284.5 information to the appropriate medical examiner or coroner instead of the local welfare  
284.6 agency, police department, or county sheriff.

284.7 (b) The medical examiner or coroner shall notify the local welfare agency, police  
284.8 department, or county sheriff in instances in which the medical examiner or coroner believes  
284.9 that the child has died as a result of maltreatment. The medical examiner or coroner shall  
284.10 complete an investigation as soon as feasible and report the findings to the police department  
284.11 or county sheriff and the local welfare agency.

284.12 (c) If the child was receiving services or treatment for mental illness, developmental  
284.13 disability, or substance use disorder, ~~or emotional disturbance~~ from an agency, facility, or  
284.14 program as defined in section 245.91, the medical examiner or coroner shall also notify and  
284.15 report findings to the ombudsman established under sections 245.91 to 245.97.

284.16 Sec. 86. Minnesota Statutes 2024, section 295.50, subdivision 9b, is amended to read:

284.17 Subd. 9b. **Patient services.** (a) "Patient services" means inpatient and outpatient services  
284.18 and other goods and services provided by hospitals, surgical centers, or health care providers.  
284.19 They include the following health care goods and services provided to a patient or consumer:

284.20 (1) bed and board;

284.21 (2) nursing services and other related services;

284.22 (3) use of hospitals, surgical centers, or health care provider facilities;

284.23 (4) medical social services;

284.24 (5) drugs, biologicals, supplies, appliances, and equipment;

284.25 (6) other diagnostic or therapeutic items or services;

284.26 (7) medical or surgical services;

284.27 (8) items and services furnished to ambulatory patients not requiring emergency care;

284.28 and

284.29 (9) emergency services.

284.30 (b) "Patient services" does not include:

- 285.1 (1) services provided to nursing homes licensed under chapter 144A;
- 285.2 (2) examinations for purposes of utilization reviews, insurance claims or eligibility,  
285.3 litigation, and employment, including reviews of medical records for those purposes;
- 285.4 (3) services provided to and by community residential mental health facilities licensed  
285.5 under section 245I.23 or Minnesota Rules, parts 9520.0500 to 9520.0670, and to and by  
285.6 residential treatment programs for children with ~~severe emotional disturbance~~ a serious  
285.7 mental illness licensed or certified under chapter 245A;
- 285.8 (4) services provided under the following programs: day treatment services as defined  
285.9 in section 245.462, subdivision 8; assertive community treatment as described in section  
285.10 256B.0622; adult rehabilitative mental health services as described in section 256B.0623;  
285.11 crisis response services as described in section 256B.0624; and children's therapeutic services  
285.12 and supports as described in section 256B.0943;
- 285.13 (5) services provided to and by community mental health centers as defined in section  
285.14 245.62, subdivision 2;
- 285.15 (6) services provided to and by assisted living programs and congregate housing  
285.16 programs;
- 285.17 (7) hospice care services;
- 285.18 (8) home and community-based waived services under chapter 256S and sections  
285.19 256B.49 and 256B.501;
- 285.20 (9) targeted case management services under sections 256B.0621; 256B.0625,  
285.21 subdivisions 20, 20a, 33, and 44; and 256B.094; and
- 285.22 (10) services provided to the following: supervised living facilities for persons with  
285.23 developmental disabilities licensed under Minnesota Rules, parts 4665.0100 to 4665.9900;  
285.24 housing with services establishments required to be registered under chapter 144D; board  
285.25 and lodging establishments providing only custodial services that are licensed under chapter  
285.26 157 and registered under section 157.17 to provide supportive services or health supervision  
285.27 services; adult foster homes as defined in Minnesota Rules, part 9555.5105; day training  
285.28 and habilitation services for adults with developmental disabilities as defined in section  
285.29 252.41, subdivision 3; boarding care homes as defined in Minnesota Rules, part 4655.0100;  
285.30 adult day care services as defined in section 245A.02, subdivision 2a; and home health  
285.31 agencies as defined in Minnesota Rules, part 9505.0175, subpart 15, or licensed under  
285.32 chapter 144A.

## ARTICLE 9

## MISCELLANEOUS

286.1

286.2

286.3 Section 1. Minnesota Statutes 2024, section 256.01, is amended by adding a subdivision  
286.4 to read:

286.5 Subd. 44. Notification of federal approval; report. (a) For any provision over which  
286.6 the commissioner has jurisdiction and that has an effective date contingent upon federal  
286.7 approval, whether the contingency is expressed in an effective date, in the text of a statutory  
286.8 provision, or in the text of an uncodified section of session law, the commissioner must  
286.9 notify the revisor of statutes of which enacted provisions contain such contingent federal  
286.10 approval and when federal approval is obtained for any such provision according to  
286.11 paragraphs (b) and (c).

286.12 (b) By July 1 of each year, the commissioner must provide the revisor of statutes; the  
286.13 director of the House Research Department; and the director of Senate Counsel, Research  
286.14 and Fiscal Analysis with a report containing a complete list of all provisions enacted since  
286.15 the preceding July 1 with an effective date contingent on federal approval.

286.16 (c) By September 1 of each year, the commissioner must provide the revisor of statutes;  
286.17 the director of the House Research Department; and the director of Senate Counsel, Research  
286.18 and Fiscal Analysis with a report containing a complete list of all statutory provisions  
286.19 previously enacted with an effective date contingent on federal approval. The commissioner  
286.20 must identify in the report which, if any, provisions received federal approval since the  
286.21 preceding September 1 and the date that federal approval for each provision was received.  
286.22 If no provisions have received federal approval since the preceding September 1, the report  
286.23 must state that fact. The revisor of statutes may authorize the commissioner to remove  
286.24 federally approved provisions from subsequent reports submitted.

286.25 (d) The reports in paragraphs (b) and (c) must be provided in a form prescribed by the  
286.26 revisor of statutes.

286.27 (e) An employee in the Department of Human Services who is responsible for identifying  
286.28 and tracking federal approval of provisions must attest to the accuracy of the reports in a  
286.29 manner prescribed by the revisor of statutes.

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

286.31 Amend the title accordingly