

1.1 moves to amend H.F. No. 729, the delete everything amendment
1.2 (H0729DE2), as follows:

1.3 Page 32, line 8, before "DISABILITY" insert "AGING AND"

1.4 Page 32, after line 8, insert:

1.5 "Section 1. Minnesota Statutes 2024, section 245A.03, subdivision 7, is amended to read:

1.6 Subd. 7. **Licensing moratorium.** (a) The commissioner shall not issue an initial license
1.7 for child foster care licensed under Minnesota Rules, parts 2960.3000 to 2960.3340, which
1.8 does not include child foster residence settings with residential program certifications for
1.9 compliance with the Family First Prevention Services Act under section 245A.25, subdivision
1.10 1, paragraph (a), or adult foster care licensed under Minnesota Rules, parts 9555.5105 to
1.11 9555.6265, under this chapter for a physical location that will not be the primary residence
1.12 of the license holder for the entire period of licensure. If a child foster residence setting that
1.13 was previously exempt from the licensing moratorium under this paragraph has its Family
1.14 First Prevention Services Act certification rescinded under section 245A.25, subdivision 9,
1.15 or if a family adult foster care home license is issued during this moratorium, and the license
1.16 holder changes the license holder's primary residence away from the physical location of
1.17 the foster care license, the commissioner shall revoke the license according to section
1.18 245A.07. The commissioner shall not issue an initial license for a community residential
1.19 setting licensed under chapter 245D. When approving an exception under this paragraph,
1.20 the commissioner shall consider the resource need determination process in paragraph (h),
1.21 the availability of foster care licensed beds in the geographic area in which the licensee
1.22 seeks to operate, the results of a person's choices during their annual assessment and service
1.23 plan review, and the recommendation of the local county board. The determination by the
1.24 commissioner is final and not subject to appeal. Exceptions to the moratorium include:

2.1 (1) a license for a person in a foster care setting that is not the primary residence of the
2.2 license holder and where at least 80 percent of the residents are 55 years of age or older;

2.3 ~~(2) foster care licenses replacing foster care licenses in existence on May 15, 2009, or~~
2.4 ~~community residential setting licenses replacing adult foster care licenses in existence on~~
2.5 ~~December 31, 2013, and determined to be needed by the commissioner under paragraph~~
2.6 ~~(b);~~

2.7 ~~(3)~~ (2) new foster care licenses or community residential setting licenses determined to
2.8 be needed by the commissioner under paragraph (b) for the closure of a nursing facility,
2.9 ICF/DD, or regional treatment center; restructuring of state-operated services that limits
2.10 the capacity of state-operated facilities; or allowing movement to the community for people
2.11 who no longer require the level of care provided in state-operated facilities as provided
2.12 under section 256B.092, subdivision 13, or 256B.49, subdivision 24; or

2.13 ~~(4)~~ (3) new foster care licenses or community residential setting licenses determined to
2.14 be needed by the commissioner under paragraph (b) for persons requiring hospital-level
2.15 care; ~~or.~~

2.16 ~~(5) new community residential setting licenses determined necessary by the commissioner~~
2.17 ~~for people affected by the closure of homes with a capacity of five or six beds currently~~
2.18 ~~licensed as supervised living facilities licensed under Minnesota Rules, chapter 4665, but~~
2.19 ~~not designated as intermediate care facilities. This exception is available until June 30, 2025.~~

2.20 (b) The commissioner shall determine the need for newly licensed foster care homes or
2.21 community residential settings as defined under this subdivision. As part of the determination,
2.22 the commissioner shall consider the availability of foster care capacity in the area in which
2.23 the licensee seeks to operate, and the recommendation of the local county board. The
2.24 determination by the commissioner must be final. A determination of need is not required
2.25 for a change in ownership at the same address.

2.26 (c) When an adult resident served by the program moves out of a foster home that is not
2.27 the primary residence of the license holder according to section 256B.49, subdivision 15,
2.28 paragraph (f), or the adult community residential setting, the county shall immediately
2.29 inform the Department of Human Services Licensing Division. The department may decrease
2.30 the statewide licensed capacity for adult foster care settings.

2.31 (d) Residential settings that would otherwise be subject to the decreased license capacity
2.32 established in paragraph (c) must be exempt if the license holder's beds are occupied by
2.33 residents whose primary diagnosis is mental illness and the license holder is certified under
2.34 the requirements in subdivision 6a or section 245D.33.

3.1 (e) A resource need determination process, managed at the state level, using the available
3.2 data required by section 144A.351, and other data and information must be used to determine
3.3 where the reduced capacity determined under section 256B.493 will be implemented. The
3.4 commissioner shall consult with the stakeholders described in section 144A.351, and employ
3.5 a variety of methods to improve the state's capacity to meet the informed decisions of those
3.6 people who want to move out of corporate foster care or community residential settings,
3.7 long-term service needs within budgetary limits, including seeking proposals from service
3.8 providers or lead agencies to change service type, capacity, or location to improve services,
3.9 increase the independence of residents, and better meet needs identified by the long-term
3.10 services and supports reports and statewide data and information.

3.11 (f) At the time of application and reapplication for licensure, the applicant and the license
3.12 holder that are subject to the moratorium or an exclusion established in paragraph (a) are
3.13 required to inform the commissioner whether the physical location where the foster care
3.14 will be provided is or will be the primary residence of the license holder for the entire period
3.15 of licensure. If the primary residence of the applicant or license holder changes, the applicant
3.16 or license holder must notify the commissioner immediately. The commissioner shall print
3.17 on the foster care license certificate whether or not the physical location is the primary
3.18 residence of the license holder.

3.19 (g) License holders of foster care homes identified under paragraph (f) that are not the
3.20 primary residence of the license holder and that also provide services in the foster care home
3.21 that are covered by a federally approved home and community-based services waiver, as
3.22 authorized under chapter 256S or section 256B.092 or 256B.49, must inform the human
3.23 services licensing division that the license holder provides or intends to provide these
3.24 waiver-funded services.

3.25 (h) The commissioner may adjust capacity to address needs identified in section
3.26 144A.351. Under this authority, the commissioner may approve new licensed settings or
3.27 delicense existing settings. Delicensing of settings will be accomplished through a process
3.28 identified in section 256B.493.

3.29 (i) The commissioner must notify a license holder when its corporate foster care or
3.30 community residential setting licensed beds are reduced under this section. The notice of
3.31 reduction of licensed beds must be in writing and delivered to the license holder by certified
3.32 mail or personal service. The notice must state why the licensed beds are reduced and must
3.33 inform the license holder of its right to request reconsideration by the commissioner. The
3.34 license holder's request for reconsideration must be in writing. If mailed, the request for
3.35 reconsideration must be postmarked and sent to the commissioner within 20 calendar days

4.1 after the license holder's receipt of the notice of reduction of licensed beds. If a request for
4.2 reconsideration is made by personal service, it must be received by the commissioner within
4.3 20 calendar days after the license holder's receipt of the notice of reduction of licensed beds.

4.4 (j) The commissioner shall not issue an initial license for children's residential treatment
4.5 services licensed under Minnesota Rules, parts 2960.0580 to 2960.0700, under this chapter
4.6 for a program that Centers for Medicare and Medicaid Services would consider an institution
4.7 for mental diseases. Facilities that serve only private pay clients are exempt from the
4.8 moratorium described in this paragraph. The commissioner has the authority to manage
4.9 existing statewide capacity for children's residential treatment services subject to the
4.10 moratorium under this paragraph and may issue an initial license for such facilities if the
4.11 initial license would not increase the statewide capacity for children's residential treatment
4.12 services subject to the moratorium under this paragraph.

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

4.14 Sec. 2. Minnesota Statutes 2025 Supplement, section 245D.091, subdivision 2, is amended
4.15 to read:

4.16 Subd. 2. **Positive support professional qualifications.** A positive support professional
4.17 providing positive support services as identified in section 245D.03, subdivision 1, paragraph
4.18 (c), clause (1), item (i), must have competencies in the following areas as required under
4.19 the brain injury, community access for disability inclusion, community alternative care, and
4.20 developmental disabilities waiver plans or successor plans:

4.21 (1) ethical considerations;

4.22 (2) functional assessment;

4.23 (3) functional analysis;

4.24 (4) measurement of behavior and interpretation of data;

4.25 (5) selecting intervention outcomes and strategies;

4.26 (6) behavior reduction and elimination strategies that promote least restrictive approved
4.27 alternatives;

4.28 (7) data collection;

4.29 (8) staff and caregiver training;

4.30 (9) support plan monitoring;

4.31 (10) co-occurring mental disorders or neurocognitive disorder;

5.1 (11) demonstrated expertise with populations being served; and

5.2 (12) must be a:

5.3 (i) psychologist licensed under sections 148.88 to 148.98, who has stated to the Board
5.4 of Psychology competencies in the above identified areas;

5.5 (ii) clinical social worker licensed as an independent clinical social worker under chapter
5.6 148E, or a person with a master's degree in social work from an accredited college or
5.7 university, with at least 4,000 hours of post-master's supervised experience in the delivery
5.8 of clinical services in the areas identified in clauses (1) to (11);

5.9 (iii) physician licensed under chapter 147 and certified by the American Board of
5.10 Psychiatry and Neurology or eligible for board certification in psychiatry with competencies
5.11 in the areas identified in clauses (1) to (11);

5.12 (iv) licensed professional clinical counselor licensed under sections ~~148B.29 to 148B.39~~
5.13 148B.5301 and 148B.532 with at least 4,000 hours of post-master's supervised experience
5.14 in the delivery of clinical services who has demonstrated competencies in the areas identified
5.15 in clauses (1) to (11);

5.16 (v) person with a master's degree from an accredited college or university in one of the
5.17 behavioral sciences or related fields, with at least 4,000 hours of post-master's supervised
5.18 experience in the delivery of clinical services with demonstrated competencies in the areas
5.19 identified in clauses (1) to (11);

5.20 (vi) person with a master's degree or PhD in one of the behavioral sciences or related
5.21 fields with demonstrated expertise in positive support services, as determined by the person's
5.22 needs as outlined in the person's assessment summary;

5.23 (vii) registered nurse who is licensed under sections 148.171 to 148.285, and who is
5.24 certified as a clinical specialist or as a nurse practitioner in adult or family psychiatric and
5.25 mental health nursing by a national nurse certification organization, or who has a master's
5.26 degree in nursing or one of the behavioral sciences or related fields from an accredited
5.27 college or university or its equivalent, with at least 4,000 hours of post-master's supervised
5.28 experience in the delivery of clinical services; or

5.29 (viii) person who has completed a competency-based training program as determined
5.30 by the commissioner.

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

6.1 Sec. 3. Minnesota Statutes 2025 Supplement, section 245D.091, subdivision 3, is amended
6.2 to read:

6.3 Subd. 3. **Positive support analyst qualifications.** (a) A positive support analyst providing
6.4 positive support services as identified in section 245D.03, subdivision 1, paragraph (c),
6.5 clause (1), item (i), must satisfy one of the following requirements as required under the
6.6 brain injury, community access for disability inclusion, community alternative care, and
6.7 developmental disabilities waiver plans or successor plans:

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

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

6.12 (3) be a ~~board-certified~~ licensed behavior analyst or a board-certified assistant behavior
6.13 analyst certified by the Behavior Analyst Certification Board, Incorporated; or

6.14 (4) have completed a competency-based training program as determined by the
6.15 commissioner.

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

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

6.23 (2) have received training prior to hire or within 90 calendar days of hire that includes:

6.24 (i) ten hours of instruction in functional assessment and functional analysis;

6.25 (ii) 20 hours of instruction in the understanding of the function of behavior;

6.26 (iii) ten hours of instruction on design of positive practices behavior support strategies;

6.27 (iv) 20 hours of instruction preparing written intervention strategies, designing data
6.28 collection protocols, training other staff to implement positive practice strategies,
6.29 summarizing and reporting program evaluation data, analyzing program evaluation data to
6.30 identify design flaws in behavioral interventions or failures in implementation fidelity, and
6.31 recommending enhancements based on evaluation data; and

6.32 (v) eight hours of instruction on principles of person-centered thinking;

7.1 (3) be determined by a positive support professional to have the training and prerequisite
7.2 skills required to provide positive practice strategies as well as behavior reduction approved
7.3 and permitted intervention to the person who receives positive support; and

7.4 (4) be under the direct supervision of a positive support professional.

7.5 (c) Meeting the qualifications for a positive support professional under subdivision 2
7.6 shall substitute for meeting the qualifications listed in paragraph (b).

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

7.8 Sec. 4. Minnesota Statutes 2024, section 256B.0625, is amended by adding a subdivision
7.9 to read:

7.10 **Subd. 77. Early intensive developmental and behavioral intervention benefit.** Medical
7.11 assistance covers early intensive developmental and behavioral intervention services
7.12 according to section 256B.0949.

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

7.14 Sec. 5. Minnesota Statutes 2025 Supplement, section 256B.0911, subdivision 13, is
7.15 amended to read:

7.16 Subd. 13. **MnCHOICES assessor qualifications, training, and certification.** (a) The
7.17 commissioner shall develop and implement a curriculum and an assessor certification
7.18 process.

7.19 (b) MnCHOICES certified assessors must have received training and certification specific
7.20 to assessment and consultation for long-term care services in the state and either:

7.21 (1) have at least an associate's degree in human services, or other closely related field;

7.22 (2) have at least an associate's degree in nursing with a public health nursing certificate,
7.23 or other closely related field; or

7.24 (3) be a registered nurse.

7.25 (c) Certified assessors shall demonstrate best practices in assessment and support
7.26 planning, including person-centered planning principles, and have a common set of skills
7.27 that ensures consistency and equitable access to services statewide.

7.28 (d) Certified assessors must be recertified every three years.

7.29 **(e) A Tribal Nation may establish the Tribal Nation's own education and experience**
7.30 **qualifications for certified assessors.**

8.1 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
8.2 whichever is later.

8.3 Sec. 6. Minnesota Statutes 2024, section 256B.0911, subdivision 32, is amended to read:

8.4 Subd. 32. **Administrative activity.** (a) The commissioner shall:

8.5 (1) streamline the processes, including timelines for when assessments need to be
8.6 completed;

8.7 (2) provide the services in this section; and

8.8 (3) implement integrated solutions to automate the business processes to the extent
8.9 necessary for support plan approval, reimbursement, program planning, evaluation, and
8.10 policy development.

8.11 (b) The commissioner shall work with lead agencies responsible for conducting long-term
8.12 care consultation services to:

8.13 ~~(1) modify the MnCHOICES application and assessment policies to create efficiencies~~
8.14 ~~while ensuring federal compliance with medical assistance and long-term services and~~
8.15 ~~supports eligibility criteria; and.~~

8.16 ~~(2) develop a set of measurable benchmarks sufficient to demonstrate quarterly~~
8.17 ~~improvement in the average time per assessment and other mutually agreed upon measures~~
8.18 ~~of increasing efficiency.~~

8.19 ~~(c) The commissioner shall collect data on the benchmarks developed under paragraph~~
8.20 ~~(b) and provide to the lead agencies an annual trend analysis of the data in order to~~
8.21 ~~demonstrate the commissioner's compliance with the requirements of this subdivision.~~

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

8.23 Sec. 7. Minnesota Statutes 2024, section 256B.0924, subdivision 3, is amended to read:

8.24 Subd. 3. **Eligibility.** Persons are eligible to receive targeted case management services
8.25 under this section if the requirements in paragraphs (a) and (b) are met.

8.26 (a) The person must be assessed and determined by the local county or Tribal agency
8.27 to:

8.28 (1) be age 18 or older;

8.29 (2) be receiving medical assistance;

8.30 (3) have significant functional limitations; and

9.1 (4) be in need of service coordination to attain or maintain living in an integrated
9.2 community setting.

9.3 (b) Except as permitted under paragraph (c), the person must be: (i) a vulnerable adult
9.4 in need of adult protection as defined in section 626.5572, or is; (ii) an adult with a
9.5 developmental disability as defined in section 252A.02, subdivision 2, or; (iii) an adult with
9.6 a related condition as defined in section 256B.02, subdivision 11, and who is not receiving
9.7 home and community-based waiver services; or is (iv) an adult who lacks a permanent
9.8 residence and who has been without a permanent residence for at least one year or on at
9.9 least four occasions in the last three years.

9.10 (c) Tribal agencies may make a determination of eligibility under Tribal governance
9.11 codes for adult protection or policy procedures consistent with section 626.5572 when
9.12 determining whether a person is a vulnerable adult in need of adult protection or an adult
9.13 with developmental disabilities or a related condition.

9.14 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
9.15 whichever is later.

9.16 Sec. 8. Minnesota Statutes 2024, section 256B.0924, subdivision 5, is amended to read:

9.17 Subd. 5. **Provider standards.** County boards ~~or~~, providers who contract with the county,
9.18 or Tribal government contracted providers are eligible to receive medical assistance
9.19 reimbursement for adult targeted case management services. To qualify as a provider of
9.20 targeted case management services the vendor must:

9.21 (1) have demonstrated the capacity and experience to provide the activities of case
9.22 management services defined in subdivision 4;

9.23 (2) be able to coordinate and link community resources needed by the recipient;

9.24 (3) have the administrative capacity and experience to serve the eligible population in
9.25 providing services and to ensure quality of services under state and federal requirements;

9.26 (4) have a financial management system that provides accurate documentation of services
9.27 and costs under state and federal requirements;

9.28 (5) have the capacity to document and maintain individual case records complying with
9.29 state and federal requirements;

9.30 (6) coordinate with county social ~~service~~ services or Tribal human services agencies
9.31 responsible for planning for community social services under chapters 256E and 256F;

10.1 conducting adult protective investigations under section 626.557, and conducting prepetition
10.2 screenings for commitments under section 253B.07;

10.3 (7) coordinate with health care providers to ensure access to necessary health care
10.4 services;

10.5 (8) have a procedure in place that notifies the recipient and the recipient's legal
10.6 representative of any conflict of interest if the contracted targeted case management service
10.7 provider also provides the recipient's services and supports and provides information on all
10.8 potential conflicts of interest and obtains the recipient's informed consent and provides the
10.9 recipient with alternatives; and

10.10 (9) have demonstrated the capacity to achieve the following performance outcomes:
10.11 access, quality, and consumer satisfaction.

10.12 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
10.13 whichever is later.

10.14 Sec. 9. Minnesota Statutes 2024, section 256B.0924, is amended by adding a subdivision
10.15 to read:

10.16 **Subd. 5a. Tribal case manager qualifications.** An individual is authorized to serve as
10.17 a vulnerable adult and developmental disability targeted case manager if the individual is
10.18 certified by a federally recognized Tribal government in Minnesota pursuant to section
10.19 256B.02, subdivision 7, paragraph (c).

10.20 Sec. 10. Minnesota Statutes 2025 Supplement, section 256B.0924, subdivision 6, is
10.21 amended to read:

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

10.30 (b) Except as provided under paragraph (m), payment for targeted case management
10.31 provided by county staff under this subdivision shall be based on the monthly rate
10.32 methodology under section 256B.094, subdivision 6, paragraph (b), calculated as one

11.1 combined average rate together with adult mental health case management under section
11.2 256B.0625, subdivision 20, ~~except for calendar year 2002. In calendar year 2002, the rate~~
11.3 ~~for case management under this section shall be the same as the rate for adult mental health~~
11.4 ~~case management in effect as of December 31, 2001.~~ Billing and payment must identify the
11.5 recipient's primary population group to allow tracking of revenues.

11.6 (c) Payment for targeted case management provided by county-contracted vendors shall
11.7 be based on a monthly rate calculated in accordance with section 256B.076, subdivision 2.
11.8 Payment for case management provided by vendors who contract with a Tribe must be made
11.9 in accordance with Indian health service facility requirements. If a Tribe chooses to contract
11.10 with a vendor receiving payment not through an Indian health service facility, the rate must
11.11 be based on a monthly rate negotiated by the Tribe. The rate must not exceed the rate charged
11.12 by the vendor for the same service to other payers. If the service is provided by a team of
11.13 contracted vendors, the team shall determine how to distribute the rate among its members.
11.14 No reimbursement received by contracted vendors shall be returned to the county or Tribe,
11.15 except to reimburse the county or Tribe for advance funding provided by the county or
11.16 Tribe to the vendor.

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

11.24 (e) Notwithstanding section 256B.19, subdivision 1, the nonfederal share of costs for
11.25 targeted case management shall be provided by the recipient's county of responsibility, as
11.26 defined in sections 256G.01 to 256G.12, from sources other than federal funds or funds
11.27 used to match other federal funds. If the service is provided by a Tribal agency, the recipient's
11.28 Tribe must provide the nonfederal share of costs, if any.

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

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

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

12.8 (i) Notwithstanding section 256B.041, county or Tribal payments for the cost of case
12.9 management services provided by county or Tribal staff shall not be made to the
12.10 commissioner of management and budget. For the purposes of targeted case management
12.11 services provided by county or Tribal staff under this section, the centralized disbursement
12.12 of payments to counties or Tribes under section 256B.041 consists only of federal earnings
12.13 from services provided under this section.

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

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

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

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

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

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

12.27 **EFFECTIVE DATE.** This section is effective January 1, 2027, or upon federal approval,
12.28 whichever is later.

12.29 Sec. 11. Minnesota Statutes 2024, section 256B.0924, subdivision 7, is amended to read:

12.30 Subd. 7. **Implementation and evaluation.** The commissioner of human services in
12.31 consultation with county boards and Tribal Nations shall establish a program to accomplish
12.32 the provisions of subdivisions 1 to 6. The commissioner in consultation with county boards

13.1 and Tribal Nations shall establish performance measures to evaluate the effectiveness of
13.2 the targeted case management services. If a county or Tribe fails to meet agreed-upon
13.3 performance measures, the commissioner may authorize contracted providers other than
13.4 the county or Tribe. Providers contracted by the commissioner shall also be subject to the
13.5 standards in subdivision 6.

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

13.7 Sec. 12. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 2, is
13.8 amended to read:

13.9 Subd. 2. **Definitions.** (a) The terms used in this section have the meanings given in this
13.10 subdivision.

13.11 (b) "Advanced certification" means a person who has completed advanced certification
13.12 in an approved modality under subdivision 13, paragraph (b).

13.13 (c) "Agency" means the legal entity that is enrolled with Minnesota health care programs
13.14 as a medical assistance provider according to Minnesota Rules, part 9505.0195, to provide
13.15 EIDBI services and that has the legal responsibility to ensure that its employees carry out
13.16 the responsibilities defined in this section. Agency includes a licensed individual professional
13.17 who practices independently and acts as an agency.

13.18 (d) "Autism spectrum disorder or a related condition" or "ASD or a related condition"
13.19 means either autism spectrum disorder (ASD) as defined in the current version of the
13.20 Diagnostic and Statistical Manual of Mental Disorders (DSM) or a condition that is found
13.21 to be closely related to ASD, as identified under the current version of the DSM, and meets
13.22 all of the following criteria:

13.23 (1) is severe and chronic;

13.24 (2) results in impairment of adaptive behavior and function similar to that of a person
13.25 with ASD;

13.26 (3) requires treatment or services similar to those required for a person with ASD; and

13.27 (4) results in substantial functional limitations in three core developmental deficits of
13.28 ASD: social or interpersonal interaction; functional communication, including nonverbal
13.29 or social communication; and restrictive or repetitive behaviors or hyperreactivity or
13.30 hyporeactivity to sensory input; and may include deficits or a high level of support in one
13.31 or more of the following domains:

13.32 (i) behavioral challenges and self-regulation;

14.1 (ii) cognition;

14.2 (iii) learning and play;

14.3 (iv) self-care; or

14.4 (v) safety.

14.5 (e) "Behavior analyst" means an individual licensed under sections 148.9981 to 148.9995
14.6 as a behavior analyst.

14.7 (f) "Clinical supervision" means the overall responsibility for the control and direction
14.8 of EIDBI service delivery, including ~~individual treatment planning~~, staff supervision,
14.9 including observation and direction; individual treatment plan development and progress
14.10 monitoring; family training and counseling; and ~~treatment review~~ coordinated care
14.11 conference coordination for each person. Clinical supervision is provided by a qualified
14.12 supervising professional (QSP) who takes full professional responsibility for the service
14.13 provided by each supervisee and the clinical effectiveness of all interventions.

14.14 (g) "Commissioner" means the commissioner of human services, unless otherwise
14.15 specified.

14.16 (h) "Comprehensive multidisciplinary evaluation" or "CMDE" means a comprehensive
14.17 evaluation of a person to determine medical necessity for EIDBI services based on the
14.18 requirements in subdivision 5.

14.19 (i) "Department" means the Department of Human Services, unless otherwise specified.

14.20 (j) "Early intensive developmental and behavioral intervention benefit" or "EIDBI
14.21 benefit" means a variety of individualized, intensive treatment modalities approved and
14.22 published by the commissioner that are based in behavioral and developmental science
14.23 consistent with best practices on effectiveness.

14.24 (k) "Employee of an agency" or "employee" means any individual who is employed
14.25 temporarily, part time, or full time by the agency that is submitting claims or billing for the
14.26 work, services, supervision, or treatment performed by the individual. Employee does not
14.27 include an independent contractor, billing agency, or consultant who is not providing EIDBI
14.28 services. Employee does not include an individual who performs work, provides services,
14.29 supervises, or provides treatment for less than 80 hours in a 12-month period.

14.30 (l) "Generalizable goals" means results or gains that are observed during a variety of
14.31 activities over time with different people, such as providers, family members, other adults,

15.1 and people, and in different environments including, but not limited to, clinics, homes,
15.2 schools, and the community.

15.3 (m) "Incident" means when any of the following occur:

15.4 (1) an illness, accident, or injury that requires first aid treatment;

15.5 (2) a bump or blow to the head; or

15.6 (3) an unusual or unexpected event that jeopardizes the safety of a person or staff,
15.7 including a person leaving the agency unattended.

15.8 (n) "Individual treatment plan" or "ITP" means the person-centered, individualized
15.9 written plan of care that integrates and coordinates person and family information from the
15.10 CMDE for a person who meets medical necessity for the EIDBI benefit. An individual
15.11 treatment plan must meet the standards in subdivision 6.

15.12 (o) "Legal representative" means the parent of a child who is under 18 years of age, a
15.13 court-appointed guardian, or other representative with legal authority to make decisions
15.14 about service for a person. For the purpose of this subdivision, "other representative with
15.15 legal authority to make decisions" includes a health care agent or an attorney-in-fact
15.16 authorized through a health care directive or power of attorney.

15.17 (p) "Mental health professional" means a staff person who is qualified according to
15.18 section 245I.04, subdivision 2.

15.19 (q) "Person" means an individual under 21 years of age.

15.20 (r) "Person-centered" means a service that both responds to the identified needs, interests,
15.21 values, preferences, and desired outcomes of the person or the person's legal representative
15.22 and respects the person's history, dignity, and cultural background and allows inclusion and
15.23 participation in the person's community.

15.24 (s) "Qualified EIDBI provider" means an individual who is a QSP or a level I, level II,
15.25 or level III treatment provider.

15.26 Sec. 13. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 16, is
15.27 amended to read:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

18.4 Sec. 14. Minnesota Statutes 2025 Supplement, section 256B.0949, subdivision 18, is
18.5 amended to read:

18.6 Subd. 18. **Site visits and sanctions.** (a) The commissioner may conduct unannounced
18.7 on-site inspections of any and all EIDBI agencies and service locations to verify that
18.8 information submitted to the commissioner is accurate, determine compliance with all
18.9 enrollment requirements, investigate reports of maltreatment, determine compliance with
18.10 service delivery and billing requirements, and determine compliance with any other applicable
18.11 laws or rules.

18.12 (b) The commissioner may withhold payment from an agency or suspend or terminate
18.13 the agency's enrollment number if the agency fails to provide access to the agency's service
18.14 locations or records, fails to comply with documentation requirements under subdivision
18.15 19, or the commissioner determines the agency has failed to comply fully with applicable
18.16 laws or rules. The provider has the right to appeal the decision of the commissioner under
18.17 section 256B.064.

18.18 Sec. 15. Minnesota Statutes 2024, section 256B.0949, is amended by adding a subdivision
18.19 to read:

18.20 Subd. 19. **Documentation requirements.** (a) CMDE and EIDBI providers must ensure
18.21 that all documentation, including but not limited to health service records and personnel
18.22 files, complies with this subdivision, subdivision 16, and Minnesota Rules, parts 9505.2175
18.23 and 9505.2197. Documentation must be complete, legible, accurate, and readily accessible.

18.24 (b) All documentation must:

18.25 (1) be legible and understandable to individuals outside service delivery;

18.26 (2) include the participant's name on each health record page and the provider's name
18.27 on each personnel file page;

18.28 (3) be signed and dated by the provider completing the documentation, with the provider's
18.29 full name, title, and credentials;

18.30 (4) be entered within 72 hours of service, and contain a record and explanation of any
18.31 delays in entry;

- 19.1 (5) clearly reflect clinical decision-making and support medical necessity;
- 19.2 (6) be securely stored in accordance with the Health Insurance Portability and
- 19.3 Accountability Act (HIPAA), Public Law 104-191;
- 19.4 (7) be stored in accordance with state and federal document retention laws;
- 19.5 (8) be available for review or audit;
- 19.6 (9) include a record of caregiver involvement where applicable; and
- 19.7 (10) include a record of supervision and oversight for staff providing services requiring
- 19.8 supervision under EIDBI policy.
- 19.9 (c) Each EIDBI service occurrence must be documented in a progress note in a manner
- 19.10 and with the information determined by the commissioner.
- 19.11 (d) All providers must maintain current personnel records for each employee in a manner
- 19.12 determined by the commissioner that include:
- 19.13 (1) the employee's name, contact information, and hire date;
- 19.14 (2) the employee's completed employment application and acknowledgment of duties;
- 19.15 (3) the job description for the employee's job with the effective date;
- 19.16 (4) verification of the employee's qualifications, including but not limited to education,
- 19.17 licenses, certifications, enrollment attestation, degrees, transcripts, and experience;
- 19.18 (5) a background study pursuant to chapter 245C with a notice from the commissioner
- 19.19 that the subject of the study is:
- 19.20 (i) not disqualified under section 245C.14; or
- 19.21 (ii) disqualified but the subject of the study has received a set-aside of the disqualification
- 19.22 under section 245C.22;
- 19.23 (6) orientation and required training the employee attended, including but not limited
- 19.24 to training on mandated reporting, cultural responsiveness, and EIDBI competencies;
- 19.25 (7) the dates of the employee's first supervised and unsupervised client contact following
- 19.26 employment;
- 19.27 (8) documentation of supervision received by the employee, including but not limited
- 19.28 to the supervisor's name and credentials, dates of supervision, supervision content, and the
- 19.29 employee's signature indicating the accuracy of the documented supervision;
- 19.30 (9) the employee's CPR and emergency response training, if required; and

20.1 (10) the employee's annual performance evaluations.

20.2 (e) If an incident occurs or the person is injured while receiving services, the provider
20.3 must document what occurred and how staff responded to the incident.

20.4 Sec. 16. Minnesota Statutes 2024, section 256B.4905, subdivision 2a, is amended to read:

20.5 Subd. 2a. **Informed choice policy.** (a) It is the policy of this state that all adults who
20.6 have disabilities and, with support from their families or legal representatives, that all
20.7 children who have disabilities:

20.8 (1) may make informed choices to select and utilize disability services and supports;
20.9 and

20.10 (2) are offered an informed decision-making process sufficient to make informed choices.

20.11 (b) It is the policy of this state that disability waivers services support the presumption
20.12 that adults who have disabilities and, with support from their families or legal representatives,
20.13 all children who have disabilities may make informed choices; and that all adults who have
20.14 disabilities and all families of children who have disabilities and are accessing waiver
20.15 services under sections 256B.092 and 256B.49 are provided an informed decision-making
20.16 process that satisfies the requirements of subdivision 3a.

20.17 (c) Lead agencies must support individuals in making informed choices by:

20.18 (1) providing complete and accurate information about available home and
20.19 community-based services and settings;

20.20 (2) providing the information in a manner that is culturally and linguistically appropriate;
20.21 and

20.22 (3) facilitating access to services that reflect the individual's preferences and assessed
20.23 needs.

20.24 (d) For individuals who are members of or affiliated with a federally recognized Tribal
20.25 Nation located within Minnesota, informed choice includes the right to receive services
20.26 administered or provided by the individual's Tribal Nation. Lead agencies must:

20.27 (1) inform individuals of services offered by Tribal Nations enrolled as Minnesota health
20.28 care providers;

20.29 (2) directly coordinate with the individual's Tribal Nation human services agency when
20.30 the individual seeks or may be eligible for services administered or provided by that Tribal
20.31 Nation; and

21.1 (3) ensure that service planning and delivery respects the individual's rights as both a
 21.2 member of a sovereign Tribal Nation and a resident of Minnesota.

21.3 (e) County lead agencies and Tribal Nation human services agencies must establish and
 21.4 maintain procedures to share updated contact information, coordinate case management,
 21.5 and provide timely referrals necessary to ensure that informed choice is fully exercised.

21.6 (f) Nothing in this section limits the sovereignty of Tribal Nations or the authority of
 21.7 Tribal governments to administer home and community-based services to their members.

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

21.9 Page 34, after line 22, insert:

21.10 "Sec. 18. Minnesota Statutes 2025 Supplement, section 256B.4914, subdivision 10a, is
 21.11 amended to read:

21.12 Subd. 10a. **Reporting and analysis of cost data.** (a) The commissioner must ensure
 21.13 that wage values and component values in subdivisions 5 to 9 reflect the cost to provide the
 21.14 service. As determined by the commissioner, in consultation with community partners
 21.15 identified in subdivision 17, a provider enrolled to provide services with rates determined
 21.16 under this section must submit requested cost data to the commissioner to support research
 21.17 on the cost of providing services that have rates determined by the disability waiver rates
 21.18 system. Requested cost data may include, but is not limited to:

21.19 (1) worker wage costs;

21.20 (2) benefits paid;

21.21 (3) supervisor wage costs;

21.22 (4) executive wage costs;

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

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

21.25 (7) administrative costs paid;

21.26 (8) program costs paid;

21.27 (9) transportation costs paid;

21.28 (10) vacancy rates; and

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

22.1 (b) At least once in any five-year period, a provider must submit cost data for a fiscal
22.2 year that ended not more than 18 months prior to the submission date. The commissioner
22.3 shall provide each provider a 90-day notice prior to its submission due date. The
22.4 commissioner may review report submissions for inaccurate, inconclusive, incomplete, or
22.5 otherwise deficient data and may remove the report from submitted status for further
22.6 verification. If a provider fails to submit required reporting data, the commissioner shall
22.7 provide notice to providers that have not provided required data 30 days after the required
22.8 submission date, and a second notice for providers who have not provided required data 60
22.9 days after the required submission date. The commissioner shall temporarily suspend
22.10 payments to the provider if cost data is not received 90 days after the required submission
22.11 date. Withheld payments shall be made once data is received and reviewed for compliance
22.12 by the commissioner.

22.13 (c) The commissioner shall conduct a random validation of data submitted under
22.14 paragraph (a) to ensure data accuracy. Providers selected to validate cost reports must
22.15 respond to the commissioner within 30 days with the requested financial documentation. If
22.16 a provider fails to respond to the commissioner with all the requested information within
22.17 30 days, the commissioner must temporarily suspend payments. The commissioner must
22.18 resume payments once the requested documentation is received. If a provider is unable to
22.19 validate the provider's costs with supporting documentation, the commissioner must require
22.20 the provider to participate in the random validation the next year that the commissioner
22.21 selects providers to report their costs. The commissioner shall analyze cost documentation
22.22 in paragraph (a) and provide recommendations for adjustments to cost components.

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

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

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

22.32 Sec. 19. Minnesota Statutes 2024, section 256B.851, subdivision 8, is amended to read:

22.33 Subd. 8. **Personal care provider agency; required reporting of cost data; training.** (a)
22.34 As determined by the commissioner and in consultation with stakeholders, agencies enrolled

23.1 to provide services with rates determined under this section must submit requested cost data
23.2 to the commissioner. The commissioner may request cost data, including but not limited
23.3 to:

23.4 (1) worker wage costs;

23.5 (2) benefits paid;

23.6 (3) supervisor wage costs;

23.7 (4) executive wage costs;

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

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

23.10 (7) administrative costs paid;

23.11 (8) program costs paid;

23.12 (9) transportation costs paid;

23.13 (10) staff vacancy rates; and

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

23.16 (b) At least once in any three-year period, a provider must submit the required cost data
23.17 for a fiscal year that ended not more than 18 months prior to the submission date. The
23.18 commissioner must provide each provider a 90-day notice prior to its submission due date.
23.19 The commissioner may review report submissions for inaccurate, inconclusive, incomplete,
23.20 or otherwise deficient data and may remove the report from submitted status for further
23.21 verification. If a provider fails to submit required cost data, the commissioner must provide
23.22 notice to a provider that has not provided required cost data 30 days after the required
23.23 submission date and a second notice to a provider that has not provided required cost data
23.24 60 days after the required submission date. The commissioner must temporarily suspend
23.25 payments to a provider if the commissioner has not received required cost data 90 days after
23.26 the required submission date. The commissioner must make withheld payments when the
23.27 required cost data is received and reviewed for compliance by the commissioner.

23.28 (c) The commissioner must conduct a random validation of data submitted under this
23.29 subdivision to ensure data accuracy. A provider selected to validate the provider's cost
23.30 reports must respond to the commissioner within 30 days with the requested financial
23.31 documentation. If a provider fails to respond to the commissioner with the requested
23.32 information within 30 days, the commissioner must temporarily suspend payments. The

24.1 commissioner must resume payments once the requested documentation is received. If a
 24.2 provider is unable to validate the provider's costs with supporting documentation, the
 24.3 commissioner must require the provider to participate in the random validation the next
 24.4 year that the commissioner selects providers to report their costs. The commissioner shall
 24.5 analyze cost documentation in paragraph (a) and provide recommendations for adjustments
 24.6 to cost components.

24.7 (d) The commissioner, in consultation with stakeholders, must develop and implement
 24.8 a process for providing training and technical assistance necessary to support provider
 24.9 submission of cost data required under this subdivision.

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

24.11 Sec. 20. Minnesota Statutes 2024, section 256S.21, subdivision 3, is amended to read:

24.12 Subd. 3. **Cost reporting.** (a) As determined by the commissioner, in consultation with
 24.13 stakeholders, a provider enrolled to provide services with rates determined under this chapter
 24.14 must submit requested cost data to the commissioner to support evaluation of the rate
 24.15 methodologies in this chapter. Requested cost data may include but are not limited to:

24.16 (1) worker wage costs;

24.17 (2) benefits paid;

24.18 (3) supervisor wage costs;

24.19 (4) executive wage costs;

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

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

24.22 (7) administrative costs paid;

24.23 (8) program costs paid;

24.24 (9) transportation costs paid;

24.25 (10) vacancy rates; and

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

24.28 (b) At least once in any five-year period, a provider must submit the required cost data
 24.29 for a fiscal year that ended not more than 18 months prior to the submission date. The
 24.30 commissioner ~~shall~~ must provide each provider a 90-day notice prior to the provider's

25.1 submission due date. The commissioner may review report submissions for inaccurate,
 25.2 inconclusive, incomplete, or otherwise deficient data and may remove the report from
 25.3 submitted status for further verification. If by 30 days after the required submission date a
 25.4 provider fails to submit required reporting data, the commissioner ~~shall~~ must provide notice
 25.5 to the provider, ~~and~~. If by 60 days after the required submission date a provider has not
 25.6 provided the required data, the commissioner ~~shall~~ must provide a second notice. The
 25.7 commissioner ~~shall~~ must temporarily suspend payments to ~~the~~ a provider if the commissioner
 25.8 has not received the required cost data ~~is not received~~ 90 days after the required submission
 25.9 date or 90 days after the Department of Human Services requests updated data. The
 25.10 commissioner must make withheld payments ~~must be made once data is received~~ when the
 25.11 required cost data is received and reviewed for compliance by the commissioner.

25.12 (c) The commissioner shall coordinate the cost reporting activities required under this
 25.13 section with the cost reporting activities directed under section 256B.4914, subdivision 10a.

25.14 (d) The commissioner shall analyze cost documentation in paragraph (a) and, in
 25.15 consultation with stakeholders, may submit recommendations on rate methodologies in this
 25.16 chapter, including ways to monitor and enforce the spending requirements directed in section
 25.17 ~~256S.2101, subdivision 3,~~ 256S.211, subdivision 4, through the reports directed by
 25.18 subdivision 2.

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

25.20 Page 35, after line 20, insert:

25.21 "Sec. **REPEALER.**

25.22 Minnesota Statutes 2024, section 256B.5012, subdivisions 4, 5, 6, 7, 8, 9, 10, 11, 12,
 25.23 14, 15, and 16, are repealed.

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

25.25 Page 41, after line 25, insert:

25.26 **"ARTICLE 6**

25.27 **HOMELESSNESS, HOUSING, AND SUPPORT SERVICES POLICY**

25.28 Section 1. Minnesota Statutes 2024, section 245.991, subdivision 3, is amended to read:

25.29 Subd. 3. **Allowable grant activities.** Grantees must provide homeless outreach and case
 25.30 management services. Projects may provide clinical assessment, habilitation and rehabilitation
 25.31 services, community mental health services, substance use disorder treatment, housing

26.1 transition and sustaining services, or direct assistance funding. Services must be provided
26.2 to individuals with a serious mental illness, substance use disorder, or ~~with a~~ co-occurring
26.3 substance use disorder, ~~and~~ who are homeless or at imminent risk of homelessness.
26.4 Individuals receiving homeless outreach services may be presumed eligible until a serious
26.5 mental illness can be verified.

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

26.7 Sec. 2. Minnesota Statutes 2024, section 245.992, subdivision 2, is amended to read:

26.8 Subd. 2. **Eligible beneficiaries.** Program activities must be provided to people with a
26.9 serious mental illness, substance use disorder, or ~~with a~~ co-occurring substance use disorder,
26.10 who meet homeless criteria determined by the commissioner.

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

26.12 Renumber the sections in sequence and correct the internal references

26.13 Amend the title accordingly