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

Page 5, line 6, after "annually" insert "complete an informed choice curriculum and"

Page 5, line 7, delete "topics" and insert "standards"

Page 5, line 32, strike "12" and insert "11a"

Page 6, line 1, strike "13" and insert "24"

Page 8, line 9, after "annually" insert "complete an informed choice curriculum and"

Page 8, line 10, delete "topics" and insert "standards"

Page 20, delete section 4

Page 23, line 12, strike "as defined in"

Page 23, line 13, delete the new language

Page 24, line 1, strike "as defined in"

Page 24, line 2, delete the new language

Page 24, line 8, strike "as defined in"

Page 24, line 9, delete the new language

Page 24, lines 16 and 27, strike "as defined in" and delete the new language

Page 52, line 28, strike "commissioner" and insert "executive board"

Page 52, after line 23, insert:

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

Subd. 2b. **Apprehend and hold orders.** (a) The court may order the treatment facility or state-operated treatment program to hold the proposed patient or direct a health officer,

peace officer, or other person to take the proposed patient into custody and transport the proposed patient to a treatment facility or state-operated treatment program for observation, evaluation, diagnosis, care, treatment, and, if necessary, confinement, when:

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

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

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

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

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

Page 54, line 18, reinstate the stricken language

Page 54, line 19, after the stricken period, insert "expires on June 30, 2027."

Page 55, after line 2, insert:

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

Subd. 2. **Apprehension; return to facility or program.** (a) Upon receiving the report of absence from the head of the treatment facility, state-operated treatment program, or community-based treatment program or the committing court, a patient may be apprehended and held by a peace officer in any jurisdiction pending return to the facility or program from

which the patient is absent without authorization. A patient may also be returned to any state-operated treatment program or any other treatment facility or community-based treatment program willing to accept the person. A person who has a mental illness and is dangerous to the public and detained under this subdivision may be held in a jail or lockup only if:

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

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

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

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

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

Subd. 6. **Transfer.** (a) A patient who is a person who has a mental illness and is dangerous to the public shall not be transferred out of a secure treatment facility unless it appears to the satisfaction of the executive board, after a hearing and favorable recommendation by a majority of the special review board, that the transfer is appropriate. Transfer may be to another state-operated treatment program. In those instances where a commitment also exists to the Department of Corrections, transfer may be to a facility designated by the commissioner of corrections.

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

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

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

(3) the need for continued institutionalization;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) For an appeal under paragraph (a), the supreme court shall refer the petition to the chief judge of the judicial appeal panel. The chief judge shall notify the patient, the county attorney of the county of commitment, the designated agency, the executive board, the head of the facility or program to which the patient was committed, any interested person, and other persons the chief judge designates, of the time and place of the hearing on the petition. The notice shall be given at least 14 days prior to the date of the hearing.

(c) Any person may oppose the petition. The patient, the patient's counsel, the county attorney of the committing county or the county of financial responsibility, and the executive board shall participate as parties to the proceeding pending before the judicial appeal panel and shall, except when the patient is committed solely as a person who has a mental illness and is dangerous to the public, no later than 20 days before the hearing on the petition, inform the judicial appeal panel and the opposing party in writing whether they support or oppose the petition and provide a summary of facts in support of their position. The judicial appeal panel may appoint court examiners and may adjourn the hearing from time to time. It shall hear and receive all relevant testimony and evidence and make a record of all

proceedings. The patient, the patient's counsel, and the county attorney of the committing county or the county of financial responsibility have the right to be present and may present and cross-examine all witnesses and offer a factual and legal basis in support of their positions. The petitioning party seeking discharge or provisional discharge bears the burden of going forward with the evidence, which means presenting a prima facie case with competent evidence to show that the person is entitled to the requested relief. If the petitioning party has met this burden, the party opposing discharge or provisional discharge bears the burden of proof by clear and convincing evidence that the discharge or provisional discharge should be denied. A party seeking transfer under section 253B.18, subdivision 6, must establish by a preponderance of the evidence that the transfer is appropriate."

Page 103, line 7, delete the new language and strike "qualified"

Page 103, line 9, before the period, insert ", and may be provided through telehealth according to section 256B.0625, subdivision 3b"

Page 109, after line 4, insert:

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

Subd. 1a. **Grounds for sanctions.** (a) The commissioner may impose sanctions against any individual or entity that receives payments from medical assistance or provides goods or services for which payment is made from medical assistance for any of the following: (1) fraud, theft, or abuse in connection with the provision of goods and services to recipients of public assistance for which payment is made from medical assistance; (2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary; (3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the individual or entity is legally entitled; (4) suspension or termination as a Medicare vendor; (5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment; (6) failure to repay an overpayment or a fine finally established under this section; (7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; (8) soliciting or receiving any remuneration as defined in section 609.542, subdivision 3, or United States Code, title 42, section 1320a-7b(b)(1), and a criminal conviction is not required; (9) paying or offering to pay any remuneration as defined in section 609.542, subdivision 2, or United States Code, title 42, section 1320a-7b(b)(2), and a criminal conviction is not required; and ~~(8)~~ (10) any reason for which an individual or entity could be excluded from participation in the Medicare

program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act. For the purposes of this section, goods or services for which payment is made from medical assistance includes but is not limited to care and services identified in section 256B.0625 or provided pursuant to any federally approved waiver.

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

Page 112, after line 8, insert:

"Sec. .... Laws 2023, chapter 70, article 7, section 34, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective ~~for background studies requested on or after August 1, 2024~~ the day following final enactment."

Page 112, line 10, before "For" insert "(a)"

Page 112, line 16, delete everything after the first period

Page 112, after line 16, insert:

"(b) Notwithstanding Minnesota Laws 1995, chapter 226, article 3, sections 50, 51, and 60, or any other law to the contrary, the joint rulemaking authority with the commissioner of corrections under Minnesota Rules, chapter 2960, does not apply to rule amendments applicable only to the Department of Human Services. A rule that is amending jointly administered rule parts must be related to requirements on the provider licensing and reporting hub.

(c) This section expires August 31, 2028."

Page 115, after line 16, insert:

"Sec. .... Minnesota Statutes 2024, section 142B.171, subdivision 2, is amended to read:

Subd. 2. **Documented technical assistance.** (a) In lieu of a correction order under section 142B.16, the commissioner shall provide documented technical assistance to a family child care or child care center license holder if the commissioner finds that:

(1) the license holder has failed to comply with a requirement in this chapter or Minnesota Rules, chapter 9502 or 9503, that the commissioner determines to be low risk as determined by the child care weighted risk system;

(2) the noncompliance does not imminently endanger the health, safety, or rights of the persons served by the program; and

(3) the license holder did not receive documented technical assistance or a correction order for the same violation at the license holder's most recent annual licensing inspection.

(b) Documented technical assistance must include communication from the commissioner to the license holder that:

(1) states the conditions that constitute a violation of a law or rule;

(2) references the specific law or rule violated; and

(3) explains remedies for correcting the violation.

~~(c) The commissioner shall not publicly publish documented technical assistance on the department's website.~~"

Page 118, line 3, after "2026" insert ", except paragraph (e), which is effective July 1, 2026"

Page 118, after line 23, insert:

"Sec. .... Minnesota Statutes 2024, section 142B.65, subdivision 9, is amended to read:

Subd. 9. **In-service training.** (a) A license holder must ensure that the center director, staff persons, substitutes, and unsupervised volunteers complete in-service training each calendar year.

(b) The center director and staff persons who work more than 20 hours per week must complete 24 hours of in-service training each calendar year. Staff persons who work 20 hours or less per week must complete 12 hours of in-service training each calendar year. Substitutes and unsupervised volunteers must complete at least two hours of training each year, and the training must include the requirements of paragraphs (d) to (g) ~~and do not otherwise have a minimum number of hours of training to complete~~.

(c) The number of in-service training hours may be prorated for ~~individuals~~ center directors and staff persons not employed for an entire year.

(d) Each year, in-service training must include:

(1) the center's procedures for maintaining health and safety according to section 142B.66 and Minnesota Rules, part 9503.0140, and handling emergencies and accidents according to Minnesota Rules, part 9503.0110;

(2) the reporting responsibilities under chapter 260E and Minnesota Rules, part 9503.0130;

(3) at least one-half hour of training on the standards under section 142B.46 and on reducing the risk of sudden unexpected infant death as required under subdivision 6, if applicable; and

(4) at least one-half hour of training on the risk of abusive head trauma from shaking infants and young children as required under subdivision 7, if applicable.

(e) Each year, or when a change is made, whichever is more frequent, in-service training must be provided on: (1) the center's risk reduction plan under section 142B.54, subdivision 2; and (2) a child's individual child care program plan as required under Minnesota Rules, part 9503.0065, subpart 3.

(f) At least once every two calendar years, the in-service training must include:

(1) child development and learning training under subdivision 3;

(2) pediatric first aid that meets the requirements of subdivision 4;

(3) pediatric cardiopulmonary resuscitation training that meets the requirements of subdivision 5;

(4) cultural dynamics training to increase awareness of cultural differences; and

(5) disabilities training to increase awareness of differing abilities of children.

(g) At least once every five years, in-service training must include child passenger restraint training that meets the requirements of subdivision 8, if applicable.

(h) The remaining hours of the in-service training requirement must be met by completing training in the following content areas of the Minnesota Knowledge and Competency Framework:

(1) Content area I: child development and learning;

(2) Content area II: developmentally appropriate learning experiences;

(3) Content area III: relationships with families;

(4) Content area IV: assessment, evaluation, and individualization;

(5) Content area V: historical and contemporary development of early childhood education;

(6) Content area VI: professionalism;

(7) Content area VII: health, safety, and nutrition; and

(8) Content area VIII: application through clinical experiences.

(i) For purposes of this subdivision, the following terms have the meanings given them.

(1) "Child development and learning training" means training in understanding how children develop physically, cognitively, emotionally, and socially and learn as part of the children's family, culture, and community.

(2) "Developmentally appropriate learning experiences" means creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, and promoting creative development.

(3) "Relationships with families" means training on building a positive, respectful relationship with the child's family.

(4) "Assessment, evaluation, and individualization" means training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality.

(5) "Historical and contemporary development of early childhood education" means training in past and current practices in early childhood education and how current events and issues affect children, families, and programs.

(6) "Professionalism" means training in knowledge, skills, and abilities that promote ongoing professional development.

(7) "Health, safety, and nutrition" means training in establishing health practices, ensuring safety, and providing healthy nutrition.

(8) "Application through clinical experiences" means clinical experiences in which a person applies effective teaching practices using a range of educational programming models.

(j) The license holder must ensure that documentation, as required in subdivision 10, includes the number of total training hours required to be completed, name of the training, the Minnesota Knowledge and Competency Framework content area, number of hours completed, and the director's approval of the training.

(k) In-service training completed by a staff person that is not specific to that child care center is transferable upon a staff person's change in employment to another child care program."

Page 120, after line 19, insert:

"Sec. .... Minnesota Statutes 2024, section 142B.70, subdivision 8, is amended to read:

Subd. 8. **Training requirements for family and group family child care.** (a) For purposes of family and group family child care, the license holder and each second adult caregiver must complete 16 hours of ongoing training each year. Repeat of topical training requirements in subdivisions 3 to 9 shall count toward the annual 16-hour training requirement. Additional ongoing training subjects to meet the annual 16-hour training requirement must be selected from the following areas:

(1) child development and learning training in understanding how a child develops physically, cognitively, emotionally, and socially, and how a child learns as part of the child's family, culture, and community;

(2) developmentally appropriate learning experiences, including training in creating positive learning experiences, promoting cognitive development, promoting social and emotional development, promoting physical development, promoting creative development; and behavior guidance;

(3) relationships with families, including training in building a positive, respectful relationship with the child's family;

(4) assessment, evaluation, and individualization, including training in observing, recording, and assessing development; assessing and using information to plan; and assessing and using information to enhance and maintain program quality;

(5) historical and contemporary development of early childhood education, including training in past and current practices in early childhood education and how current events and issues affect children, families, and programs;

(6) professionalism, including training in knowledge, skills, and abilities that promote ongoing professional development; and

(7) health, safety, and nutrition, including training in establishing healthy practices; ensuring safety; and providing healthy nutrition.

(b) A provider who is approved as a trainer through the Develop data system may count up to two hours of training instruction toward the annual 16-hour training requirement in paragraph (a). The provider may only count training instruction hours for the first instance in which they deliver a particular content-specific training during each licensing year. Hours counted as training instruction must be approved through the Develop data system with attendance verified on the trainer's individual learning record and must be in Knowledge

and Competency Framework content area VII A (Establishing Healthy Practices) or B (Ensuring Safety).

(c) Substitutes and adult caregivers who provide care for 500 or fewer hours per year must complete a minimum of one hour of training each calendar year, and the training must include the requirements in subdivisions 3, 4, 5, 6, and 9."

Page 121, after line 17, insert:

"Sec. .... Minnesota Statutes 2024, section 142C.12, subdivision 6, is amended to read:

Subd. 6. **In-service training.** (a) The certified center must ensure that the director and all staff persons, including substitutes and unsupervised volunteers, are trained at least once each calendar year on health and safety requirements in this section and sections 142C.10, 142C.11, and 142C.13.

(b) The director and each staff person, not including substitutes, must complete at least six hours of training each calendar year. Substitutes must complete at least two hours of training each calendar year. Training required under paragraph (a) may be used toward the hourly training requirements of this subdivision."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly